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**PRESCRIBING AID COORDINATION IN
UGANDA'S HEALTH SECTOR**

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DECLARATION

Date:

I declare that, except where otherwise indicated, this thesis is entirely my own work, and that no part of it has been submitted for any other degree or professional qualification.

Emma Michelle Taylor

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ABSTRACT

This thesis aims to contribute to the body of work that seeks to unpack development by asking: how does development work? Using a purposive case study of Uganda and taking a mixed methods approach, the thesis explores the reality behind the rhetoric of aid coordination in a developing health sector, questioning the premise that coordination is pursued exclusively to improve the efficacy of official development assistance (as inferred by partners' vocal commitments to the tenets of the Paris Declaration on Aid Effectiveness). The study focuses on the member groups currently empowered to join Uganda's most important multi-stakeholder forum for health - the Health Policy Advisory Committee - finding that all members are guilty of picking and choosing from a checklist of voluntary coordination commitments. This is found to be at once logical - for facilitating the semblance of partnership between a disparate grouping of stakeholders with differing mod operandi, agency objectives and tolerance for risk – and advantageous - for masking difference and allowing outwardly homogenous groupings like the Health Development Partners to speak with “one voice” when addressing the Ugandan government. Most importantly of all however, partial adherence to the aid coordination ethos is found to permit the framing that aid to Uganda is at once necessary and well targeted, as the Government of Uganda actively invites its partners to participate in the processes of government at the central level. Such tangible commitments to the tenets of partnership and transparency are integral to maintaining donor confidence in the aftermath of two financial scandals involving the Global Fund for AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation in 2005. In sum, the thesis argues that while on the surface coordination appears important for its internal significance - as an organising principle to improve the effectiveness of aid - in fact, the value of coordination stems from its external significance. Coordination creates a façade of unity which permits the continuance of aid flows to Uganda, with coordination activities now playing a pivotal role in determining who gives and receives aid, and how it should be spent.

LIST OF ACRONYMS AND ABBREVIATIONS

ADPs	AIDS Development Partners
AFDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome/Acquired Immunodeficiency Syndrome
AHSPR	Annual Health Sector Performance Report
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
BFP	Budget Framework Paper
BS	Budget Support
BTC	Belgian Technical Cooperation
CCM	Country Coordinating Mechanism (for the GFATM)
CHOGM	Commonwealth Heads of Government Meeting
CSF	Civil Society Fund
CSO	Civil Society Organisation
CP	Condition Precedent (of the GFATM)
DANIDA	Danish International Development Agency
DFID	Department for International Development (UK)
DoL	Division of Labour Exercise
DPs	Development Partners
EMCL	Essential Medicines Credit Line
ESRC	Economic and Social Research Council (UK)
FBOs	Faith-Based Organisations
FMA	Financial Management Agent
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunisation
GDP	Gross Domestic Product
GFATM	Global Fund To Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GoU	Government of Uganda
GTT	Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors
HDPs	Health Development Partners
HIPC	Heavily Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HPAC	Health Policy Advisory Committee
HQ	Headquarters
HSPS	Health Sector Programme Support (Danida)
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
ICC	Inter-agency Coordinating Committee
IGG	Inspector General of Government
IOM	Institute of Medicine
IRISH AID	Irish Agency for International Development
IRS	Indoor Residual Spraying

JICA	Japan International Cooperation Agency
JMS	Joint Medical Stores
JRM	Joint Review Mission
JSI	John Snow Inc
LDC	Less Developed County
LDG	Local Donor Group
LDPG	Local Development Partners Group
LFA	Local Fund Agent (for the GFATM)
LTIA's	Long-Term Institutional Arrangements
MACIS	Malaria and Childhood Illness NGO Secretariat
MAP	The World Bank's Multi-Country HIV/AIDS Program for Africa
MDGs	Millennium Development Goals
MEMA	Monitoring and Evaluation Management Agent
MoFPED	Ministry of Finance, Planning and Economic Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSF	Médecins Sans Frontières
MTEF	Medium-Term Expenditure Framework
MTR	Mid-Term Review of <i>HSSP II</i>
NDP	National Development Plan
NGO	Non Governmental Organisation
NHA	National Health Assembly
NHP	National Health Policy
NMS	National Medical Stores
NPO	National Professional Officer (at WHO)
NRM	National Resistance Movement
NSA	National Strategy Applications (for the GFATM)
NSP	National HIV & AIDS Strategic Plan 2007/08-2011/12: Towards Universal Access
NTDs	Neglected Tropical Diseases
ODA	Official Development Assistance/Overseas Development Assistance
ODI	Overseas Development Institute
PAF	Poverty Action Fund
PC	Partnership Committee (of the Uganda AIDS Partnership)
PD	Paris Declaration on Aid Effectiveness
PDG	Partners for Democracy and Governance
PEAP	Poverty Eradication Action Plan
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PMI	President's Malaria Initiative
PNFP	Private Not-For-Profit
PPs	Partnership Principles
PR	Principal Recipient (for the GFATM)
RFA	Request For Applications
SCMS	Supply Chain Management System
SIDA	Swedish International Development Cooperation Agency

SMC	Senior Management Committee (of MoH)
SWAp	Sector-Wide Approach
SWG	Sector Working Group
TA	Technical Assistance
TB	Tuberculosis
TMA	Technical Management Agent
TMC	Top Management Committee (of MoH)
TORs	Terms of Reference
TRP	Technical Review Panel (of the GFATM)
TWG	Technical Working Group
UA	Units of Account
UAC	Uganda AIDS Commission
UBOS	Ugandan Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
OECD	Organisation for Economic Cooperation and Development
OECD DAC	OECD Development Assistance Committee
OGAC	Office of the US Global AIDS Coordinator
UEDMP	Uganda Essential Drugs Management Programme
Ug. Shs	Uganda Shillings (the national currency of Uganda)
UJAS	Uganda Joint Assistance Strategy
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
USH	Ugandan Shillings (the national currency of Uganda)
WB	World Bank
WCO	WHO Country Office
WHO	World Health Organisation
WR	World Health Organisation Representative

CHAPTER ONE:

PREScribing AID COORDINATION IN UGANDA'S HEALTH SECTOR: AN INTRODUCTION

Introduction

When it was revealed that Ugandan Shillings (USH) 3.2 billion of Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) monies (Mugisa and Nsambu 2009) and USH 1.6 billion of Global Alliance for Vaccines and Immunisation (GAVI) monies (Afedraru 2008) had been misappropriated in Uganda in 2005, the development community was left aghast.¹ Long heralded as Africa's "success" story (Barkan 2005), Uganda has emerged as one of the most oft cited case studies in the case made in favour of development aid. Both the original revelations and the fear of impunity in the aftermath – where the road to securing prosecutions has proved long and uncertain - have rendered it harder than ever for Development Partners to continue to give official development assistance (ODA) to Uganda in good conscience.

Drawing on the logic of strength in numbers, it was remarkable therefore that a group of Development Partners came together in February 2010 to issue the government with this joint ultimatum: clean up public sector corruption or you can expect to see aid withheld, aid reduced and/or re-programming away from direct budget support (Observer Media Ltd 2010).² The implication of this *coordinated* threat from a group of *coordinated* donors for the focus of this thesis is huge - for belying in one fell

¹ Converting these figures into dollars, \$1.5 million of GFATM grants and \$750,000 of GAVI funds were unaccounted for (using currency conversion site: <http://coinmill.com> on 20/03/10).

² The ultimatum was delivered as part of a joint statement issued by Uganda's "Development Partners" at the National Budget Workshop, 25-26th February 2010. Although attributed to Uganda's "Development Partners" in the press, the official name of this grouping is the Local Development Partners Group (LDPG), an umbrella grouping encompassing all of Uganda's various development partner sub-groupings (e.g. the Health Development Partners). See Appendix 1 for a visual representation of the Development Partner coordination structure in Uganda. See Appendix 3 for the Local Development Partner Group's Terms of Reference.

swoop the extolled view that coordination between stakeholders at the level of the aid recipient country is carried out solely in the pursuit of aid effectiveness.

This thesis aims to explore the truth of the aid coordination ethos using a purposive case study of Uganda's health sector. There, multiple coordination fora are to be found in operation, with donor, government and nongovernmental partners all empowered to opt in and opt out of multiple alliances (that said, access is not a blanket commodity and is mediated by a host of bureaucratic devices, including memorandums of understanding and terms of reference). The proffered reasons for involvement in such groupings centre on the tenets of aid effectiveness as encapsulated in the 2005 Paris Declaration on Aid Effectiveness (Paris High-Level Forum 2005): ownership, alignment, harmonisation, managing for results and mutual accountability (see box 2 on p27). However, a closer look at the empirical evidence suggests two things. Firstly that meaningful coordination, of the type extolled in Paris, isn't fully reflected in the reality of coordination activities on the ground. Secondly, that stakeholders involved in the country's health sector – acting individually and collectively - have devised subtle ways to subvert Uganda's coordination architecture to their own ends, ends that at times appear to have little to do with the principles of ownership, harmonisation or alignment. Yet in spite of the often tenuous connection to the tenets of aid effectiveness, ODA remains the lifeblood of all centre-led relationships in Uganda, with coordination now playing a pivotal role in determining who gives aid (and how much), who gets it (and in what modality) and how it should be spent (in short, in getting policy right). Indeed, while Uganda's international reputation hangs in the balance it is remarkable to note how coordination has provided the means to continue with the framing that Uganda is still a deserving recipient of development aid. Publicly ticked off and publicly penitent, and with everyone eager to build public sector capacity, all partners are doing just enough to keep the money moving.

Situating the Research

This thesis concerns itself with the contested terrains of aid and development. These concepts, while at least superficially familiar to the majority of people, have the unfortunate knack of increasing in complexity the deeper you look into them – a fact

not helped by the shifting and conflicting definitions of the terms in common usage, and/or by the perplexing array of aid and development-related acronyms that have proliferated since the era of development officially began (President Truman's 1949 Inaugural Speech is traditionally depicted as its starting point). Therefore, in order to help mitigate against some of the worst frustrations this thesis may pose to readers unfamiliar with the specialisation, I will attempt to be explicit about the definitions I draw upon throughout this thesis – through the use of text boxes, diagrams, footnotes etc – and I will apologise in advance for the dense use of acronyms. Subsequently, see box 1 for a brief introduction to many of the central aid concepts introduced over the course of this thesis, and find a second *pullout* copy of the acronym list to assist with reading. Finally, be aware that this thesis deals explicitly with official development assistance to Uganda's health sector, of the sort that can be channelled through government budgets, via donor projects and nongovernmental actors.

The truth is that the worlds of aid and development are complex. Moreover, they appear unusually susceptible to internal subdivision (Riddell 2007) - whereby new areas are continually being marked out for arcane specialisation (a recent example being the 'good governance' agenda), which only serves to convolute the terminology and compound the confusion of the layperson. Indeed, this is why studies like this - informed by the school of post-development critique which deems it pertinent to ask 'what does development do, and how does it do it?' - have been proliferating. It is, quite simply, too easy for the esoteric language and accoutrements of development aid to subjugate the casual observer, and to reduce the contestations surrounding ODA to moral platitudes and poorly grounded debates over impact.

Ferguson (1990) and Escobar (1995) – the original 'deconstructors of development' - laid the foundations for the sort of post-development critique I am attempting with this study. More recently, Crewe and Harrison (1998) and Mosse (2005) have made important contributions to the genre. Viewed in sum, each of their works have important methodological lessons to teach the researcher of development-based organisations, proposing a critical approach which refuses to take discourse at its word; which warns the researcher to stay alert to the common disconnect between the

plans and outcomes of aid funded interventions; which challenges the notion of apolitical aid; and which advises the researcher to reinstate the complex agency of multiple actors into the development process.

Ferguson considers the function of discourse in light of Foucault's (1971, 1973) idea of a conceptual "apparatus," considering it as an elaborate contraption which *does* something and which has its own effects that go beyond concealing the true intention of development projects. In this way, he observes the way in which the discourse of the World Bank has served to reconstruct Lesotho as a "generic 'LDC' [less development country] – a country with all the right deficiencies, the sort that 'development' institutions can easily and productively latch on to" (Ferguson 1990: 70).

In carrying out his analysis Ferguson advocates the anthropological "decentred" approach, underscoring that a growing body of literature within this approach has noted the discrepancy between planned social interventions and their outcomes, which at times has resulted in formations of control unintended at the outset (and potentially unrecognised at the end), but which are made all the more effective by virtue of being "subjectless" (e.g. Foucault's *Discipline and Punish* 1979).³ Subsequently, when Ferguson uncovers the unintended or "instrument-effects" (Ferguson 1990: 256, citing Foucault 1979) of the World Bank's Thaba-Tseka Project in Lesotho - "a resultant constellation that has the effect of expanding the exercise of a particular sort of state power while simultaneously exerting a powerful depoliticizing effect" – he is forced to conclude that "it may be that what is most important about a 'development' project is not so much what it fails to do but what it does do; it may be that its real importance lies in the side-effects..." (Ferguson 1990: 254).

³ The "decentred" approach locates the intelligibility of events and transformations not in the intentions guiding key development actors but "in the systematic nature of the social reality which results from those actions" (Ferguson 1990: 18).

On Ferguson's reading therefore, "'development' is the name not only for a value, but also for a dominant problematic or interpretive grid through which the impoverished regions of the world are known to us" (Ferguson 1990: xiii). The problematic is itself a part of the "development apparatus" or "'an anti-politics machine,'" which acts by "depoliticizing everything it touches...all the while performing, almost unnoticed, its own pre-eminently political operation of expanding bureaucratic state power" (Ferguson 1990: xv).

Like Ferguson, Escobar (1995) has also likened the discourse of development to a conceptual apparatus - used to produce knowledge about, and to exercise power over, the third world via a process of problematisation. As such he asks his readers to consider development firstly as "a regime of representation," (Escobar 1995: 6) and - because it ignores the voices of the people it pertains to help, permitting development institutions and professionals to reproduce themselves unchallenged - as a "violence of representation" (Escobar 1995: 153). Again like Ferguson, Escobar is troubled by the manner in which development discourse appears to render development interventions apolitical, maintaining that it is possible to chart the construction of a notion of underdevelopment through the discourse of economics, which "conceived of development as something to be achieved by the more or less straightforward application of savings, investment, and productivity increases" (Escobar 1995: 83). In this way, it not only excluded structural, political and cultural factors but also occupied the discursive space to such an extent that it crowded out all alternatives. This has had the effect of depoliticising and decontextualising problems in order to recast them in terms of objective science.

In a similar vein to Escobar, Mosse (2005) has identified the ability of development discourse to create "regimes of representation", arguing that:

"agencies for international development devote their policy processes to constantly revising and re-framing development so as to shore up legitimacy in a fast-changing political environment...aid or development demand constant conceptual work to remain politically and morally viable" (Mosse 2005: 1).

From this stance, Mosse casts doubt on the logical assumption that development policy guides practice, his own judgement being that, “At best, the relationship...is understood in terms of an unintended ‘gap’ between theory and practice,” causing Mosse to posit, “what if development practice is not driven by policy?...What if, instead of policy producing practice, practice produces policy in the sense that actors in development devote their energies to maintaining coherent representations regardless of events?” (Mosse 2005: 2). Indeed, this departure is the premise behind Mosse’s study, which asks not whether, but *how* development works.

Mosse is dismissive of Ferguson’s and Escobar’s critical view of policy. Firstly, for taking the failure of development to be self-evident, and secondly, for substituting the intended goals of development with ill-perceived, unintended ones. This, claims Mosse “merely replaces the instrumental rationality of policy with the automaticity of the machine” (Mosse 2005: 5). Moreover, he is equally critical of the instrumental view of policy as rational problem solving on the premise that it envisages development as something to be controlled (which in Mosse’s opinion constitutes the fatal flaw of the “new managerialism”) and is distinguished by both the “morality of the black box” (Quarles van Ufford and Giri 2003), and the separation of planning and implementation.⁴ In opposition to these views therefore, Mosse states his aim “to reinstate the complex agency of actors in development at every level, and to move on from the image of duped perpetrators and victims...as well as to revise the false notion of all-powerful Western development institutions” (Mosse 2005: 6).

In allusion to this complexity, Mosse notes how recent ethnographies have started to blur the boundaries between planning and resistance frameworks - drawing on Foucault’s (1978) conception of governmentality, which allows for degrees of negotiation in the development relationship. From this viewpoint, Mosse argues that because in reality the operational control of development agencies over practices is

⁴ Mosse argues that “international development is characterised by a new managerialism, driven by two trends: on the one hand, a narrowing of the *ends* of development to quantified international development targets for the reduction of poverty, ill-health and illiteracy...but, on the other, a widening of its *means*...In the extreme, nothing short of the managed reorganisation of state and society is necessary to deliver on the enormously ambitious goal of eliminating world poverty” (Mosse 2005: 3).

quite limited, the focus of academics investigating development-based organisations should shift to investigate how these agencies control their *interpretation* of events, rather than simply the events themselves.

Mosse suggests that successful development projects require *interpretive communities* whereby “the more interests that are tied up with...particular interpretations the more stable and dominant development policy models become” (Mosse 2005: 8). Moreover, that the cohesion of such communities is assisted by the development industry’s preoccupation with ambiguous/flexible terms or “master metaphors” (e.g. ‘participation’), and by the constant work of *translation* carried out by skilled brokers who turn policy goals into practical interests and vice versa (a role often undertaken by “experts” within project consultancy teams) (Mosse 2005: 9). In light of his conclusions, Mosse deems that the ethnographic task is to reveal how, despite the fragmentation of stakeholder interests, development actors are constantly engaged in creating unity through political acts of *composition* (Mosse 2005 citing Latour 2000).

Like Mosse, Crewe and Harrison (1998) reject the automaticity of the machine in development inferred by Ferguson, pointing out that: “The development ‘machine’ too is composed of a number of parts which are clearly capable of independent action, and whose identities are not fixed or rigid but capable of adapting to circumstances...” (Crewe and Harrison 1998: 187). Arguing in short, that there isn’t a coordinated conspiracy at work in development and underscoring that plenty of projects do fail. Instead, and again like Mosse, the pair seek to reinstate the agency of multiple players to the development enterprise - refuting the ‘us and them’ dichotomy implied by Ferguson and Escobar - and suggesting that:

“Rather than honing in on the perspective of one set of stakeholders in development (the developers or the beneficiaries, for example), it is more useful to look at the relationships...This involves examining the ‘interface’ between many different group and actors” (Crewe and Harrison 1998: 19).

Crewe and Harrison also highlight the important role of assumptions in development, whereby quick decision making and the need to account for unpredictable results can

sometime impel development workers to arrive at assumptions which involve the simplification of complex social reality. Such simplifications, they argue, can on occasion serve as “the basis for action” (Crewe and Harrison 1998: 4)

In my study, I have been heavily influenced by the post-development thinking of Ferguson, Escobar, Mosse, Crewe and Harrison, and the key works of Foucault and Latour. Yet while I accept the idea of discourse as a conceptual apparatus and concur with the assessment that development has too often downplayed its political connotations (in short, with two of the ideas proffered by Ferguson and Escobar) I align myself with the more nuanced view of development proposed by Mosse and Crewe and Harrison - the view that recognises that the development process is influenced by a multitude of stakeholders and variables, and not simply by the wicked intentions of the ‘developers’. It is thus the interface – where “the different actors in the development process” combine “with the structural and historical specifics of their institutional location” that has provided the focus of this study (Crewe and Harrison 1998: 5). As Crewe and Harrison have observed, such an investigation “creates a messier view of reality than many of the ‘deconstructors of development’ appear to imply, but arguably a more accurate one” (Crewe and Harrison 1998: 5).

Finally, my investigation into aid coordination activities in Uganda’s health sector has been informed by the strand of development thought to challenge the aid industry’s current preoccupation with promoting ‘participation’ in aid-recipient countries. Here I align myself with Cooke and Kothari (2001), Rahnema (2003) and Hickey and Mohan (2004), who are all troubled by the manner in which participation is promoted as a technical and/or apolitical undertaking, when in fact the very act of partaking is inherently political. Thus while I, like Cooke and Kothari “would resist being labelled anti-participation” (Cooke and Kothari 2001: 13), given the current power imbalance that exists both within the aid relationship and between the developing nation state and its citizenry, I remain alert to the currents of power underpinning participation activities, and to the potential for the newly initiated to be co-opted and/or manipulated as a result of their invitation to take part.

The Resilience of Aid's Flight Forward

The implied relationship between the terms 'aid' and 'development' is significant. The former is commonly depicted as a mechanism for delivering the latter. Yet as with many of the claims made on behalf of development aid – including the suggestions that aid can contribute to macroeconomic growth and/or poverty reduction - this assumption is openly disputed. Former Senior Vice President of the World Bank Joseph Stiglitz has formally stated that: “If there is a consensus today about what strategies are likely to help the development of the poorest countries it is this: there is no consensus...” (2005: 1). While Roger Riddell, having reviewed the existing evidence base on aid's impact for his study *Does Foreign Aid Really Work?*, concluded that:

“One way in which the necessity of aid has been understood is that ‘aid is necessary for development’ – meaning that without aid, there can be no development. One of the main conclusions to be drawn from a dispassionate review of the evidence is that this is not true: it cannot be sustained as a general proposition. Development, growth and poverty reduction do take place without recourse to aid” (Riddell 2007: 255).

In light of such critiques, which have served to call into question the causal chains between the inputs and outputs of development aid, it is remarkable that in the first decade of the Twenty-First Century the world is enjoying a massive aid revival. More than that, figures suggest that we are currently on track to witness the fastest expansion in official aid since records began (OECD 2006: 16). Thus it is the resilience of ODA – in the face of its critics - that remains significant. Such resilience, Emmerij (2004), Mosse (2005) and Riddell (2007) have argued, has been achieved via the constant reinvention and re-branding of the product. To summarise, some of the major shifts in the thinking over aid which have helped galvanise its durability have included: aid's macroeconomic focus being diffused by a diverse social and poverty agenda; the principle of aid conditionality being replaced by that of aid selectivity; the emergence of programme aid as the preferable alternative to

project aid; and the renewed pro-aid advocacy in the Twenty-First Century, which has called for increased, better quality and mutually accountable aid. I will provide a brief synopsis of these shifts now.

Diffusing Aid's Macroeconomic Focus

The theory that aid might be able to stimulate economic growth in developing countries was revitalised for the Twenty-First Century by Hansen and Tarp (2000) who, having tested three generations of economic models, found not only positive links between aid and investment, between aid and growth, and between savings and growth, but also concurred with the Burnside and Dollar (1997) finding that aid effectiveness in the growth process depends on the quality of economic policies in place.⁵ This updated investigation led the pair to conclude that “It is neither analytically defensible nor empirically credible to argue from the outset that aid never works” (Hansen and Tarp 2000: 103). While Hansen and Tarp’s work continues to prove popular (see Foster and Keith 2003, and Pronk 2004) it has also attracted its critics (Erixon 2005).

What remains remarkable about aid however, is its ability to sustain diverging theories simultaneously. Thus since the 1970s, the scope of development aid has gradually widened to assume a poverty focus diffused with social considerations giving rise to the idea that aid holds the potential to reduce global poverty. And while the current thinking on aid experienced a few detours along the way (in the form of 1980s structural adjustment and 1990s ‘aid fatigue’), that served to delay the universal acceptance of aid’s diffused social focus, the World Bank’s introduction of Poverty Reduction Strategy Papers and the adoption of the Millennium Development Goals (MDGs) in 2000 have cemented aid’s reputation for poverty reduction.

⁵ The models they tested were: the Harrod-Domar growth model and the Chenery and Strout two-gap model; Pananek (1972); and Burnside and Dollar (1997).

Box 1: Glossary of Key Aid Terms

Basket/Pooled Funding:

"Basket funding is the joint funding by a number of donors of a set of activities through a common account, which keeps the basket resources separate from all other resources intended for the same purpose. The planning and other procedures and rules governing the basket fund are therefore common to all participating donors, but they may be more or less in conformity with the public expenditure management procedures of the recipient government. A basket may be earmarked to a narrow or a wider set of activities (e.g. a sector or a sub-sector). The term "pool(ed) funding" is sometimes used instead of basket funding" (Danish Ministry of Foreign Affairs 2006:2).

Development:

The simplest understanding of development is "good change" (Chambers 1997) but in fact there is no universal agreement on a definition. Thomas (2002) has shed light on the issue by suggesting that 'development' is used in three main senses: "a vision or measure of a desirable society; an historical process of social change; deliberate efforts at improvement by development agencies" (Thomas 2002: 48).

Direct budget support:

"Direct budget support is defined as a method of financing a partner country's budget through a transfer of resources from a donor to the partner government's national treasury. The funds thus transferred are managed in accordance with the recipient's budgetary procedures" (OECD 2010).

Division of Labour Exercise:

"Donors divide sectors and thematic areas among themselves with a view to avoiding the crowding of donors in particular sectors and areas. The consequence will usually be that donors end up focusing on a relatively limited number of areas or sectors and sometimes have to even disengage from some areas or sectors" (Danish Ministry of Foreign Affairs 2006: 3).

General budget support:

"General budget support is a sub-category of direct budget support. In the case of general budget support, the dialogue between donors and partner governments focuses on overall policy and budget priorities" (OECD 2010).

Good Governance:

Rising in prominence since the latter half of the 1990s, the emergence of the 'good governance' agenda is best tracked through the policy evolution of the World Bank (1989; 1992; 1997a; 1997b; 1998; 2000; 2006). The Bank has defined governance as "the means in which power is exercised in the management of a country's economic and social resource for development," and 'good governance' as "synonymous with sound development management" (World Bank 1992: 1).

Global Health Initiative:

In the first decade of the Twenty-First Century, a plethora of new funding initiatives have emerged, drastically increasing the level of aid for health in low- and middle-income countries. Most GHIs involve public-private partnerships and share "a desire for lean and efficient organizational structures and an emphasis on linking inputs to quantifiable results" (WHO 2008: 3). So far the initiatives have tended to target specific diseases. Currently, the three largest Global Health Initiatives operating in Uganda are the President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria, and the Global Alliance for Vaccines and Immunisation.

Millennium Development Goals (MDGs):

The MDGs are set of eight goals, adopted by the international community in 2000, which promote the role of human capital in driving development. These are: 1) Eradicate extreme poverty and hunger; 2) Achieve universal primary education; 3) Promote gender equality and empower women; 4) Reduce child mortality; 5) Improve maternal health; 6) Combat HIV/AIDs, malaria and other diseases; 7) Ensure environmental sustainability 8) Develop a global partnership for development (UN Millennium Project 2005).

Official Development Assistance/Development Aid:

“ODA consists of flows to developing countries and multilateral institutions by official agencies, including state and local governments, or by their executive agencies, each transaction of which meets the following two criteria: (1) it is administered with the promotion of the economic development and welfare of developing countries as its main objective, and (2) it is concessional in character and contains a grant element of at least 25 per cent (calculated at a rate of discount of 10 per cent) (Führer 1994: 25).

Poverty Reduction Strategy Paper:

Poverty Reduction Strategy Papers (PRSPs) are prepared by countries through a participatory process involving domestic stakeholders as well as external development partners, including the World Bank and International Monetary Fund. Updated every three years with annual progress reports, PRSPs describe the country's macroeconomic, structural and social policies and programs over a three year or longer horizon to promote broad-based growth and reduce poverty, as well as associated external financing needs and major sources of financing. <http://www.imf.org/external/np/prsp/prsp.asp> [Accessed 30/09/10]

Programme-Based Aid Approaches:

“Programme-based approaches are a way of engaging in development cooperation based on the principles of co-ordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation. Programme-based approaches share the following features:

- Leadership by the host country or organisation.
- A single comprehensive programme and budget framework
- A formalised process for donor coordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement
- Efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation

Donors can support and implement programme-based approaches in different ways and across a range of aid modalities including budget support, sector budget support, project support, pooled arrangements and trust funds” (OECD 2010).

Project Aid:

“Project aid is directed toward an individual development intervention designed to achieve specific objectives within specified resources and implementation schedules (which may or may not be implemented within the framework of a broader programme)” (Danish Ministry of Foreign Affairs 2006: 9).

Sector-Wide Approach (SWAp):

“What characterizes a SWAp is the engagement of donor agencies in supporting a recipient-government-led, sector-wide strategy, as well as agreement between donors and the recipient government on the broad parameters for implementing and managing the sector strategy within a medium-term expenditure framework” (Riddell 2007: 196). In Uganda the SWAp in the health sector has been in place since 2000.

This is not to suggest however, that aid's new focus has gone unchallenged (Healey and Killick 2000, Easterly 2002, and Erixon 2005 have all offered critiques, and the MDGs in particular have come under heavy fire (Easterly 2002, 2007; Foster and Keith 2003; Hamner *et al.* 2000; Mehrota 2004)). Yet it is aid's durability that remains its defining quality, and the aid donors – rather than the critics - that continue to dictate its remit.

Introducing Aid Selectivity

Following disappointing results and widespread criticism (see Collier 1999; Kanbur 2000; Singh 2004) the donor practice of aid conditionality has *officially* been phased out since the later 1990s and replaced with aid selectivity. This means that instead of ODA being provided with conditions attached in the hope that the recipient country will reform their policies/practices (therefore making the aid more effective), the aid recipient is chosen on the basis of having *already* met certain criteria, suggesting that the allocated aid might be used more effectively. The practice of aid selectivity is underpinned by the Dollar and Burnside (1997) argument that while aid has the potential to promote growth in a good policy environment it cannot buy policies in a bad one. Some other arguments used to promote selectivity include the idea that it is less intrusive on national sovereignty, that policies will prove more effective because of their 'domestic' ownership, and that by targeting 'good' performers, aid will have a greater short-term impact on growth and poverty reduction (Boyce 2004).

In contrast, the main criticisms levelled against selectivity are that the countries in the greatest need of aid will be the least able to attract it (Hout 2004; Riddell); that the criteria being devised by donors to judge a country's eligibility as part of the 'good governance' agenda (e.g. the World Bank's Country Policy and Institutional Assessment) are methodologically problematic (Court 2006; Riddell 2007); and that many donors continue to give politically motivated aid (Alesina and Dollar 1998; Alesina and Weder 1999; Grant and Nijmann 1998; Erixon 2005).

Finally, it is not yet clear that the rhetoric of phasing out aid conditionality in favour of selectivity is even well reflected in current donor practices (Mosley and Eeckhout 2000). With the onset of performance-based Global Health Initiatives such as the

GFATM (which requires recipients to meet a long list of conditions termed ‘conditions precedent’ before allocating grants), it would appear that aid conditionality is still in very much en vogue.⁶

Project To Programme Aid

Providing another example of how donor rhetoric can sometimes outpace action, the popularity of project aid as a disbursement mechanism has officially been on the decline since the 1970s, thus allowing new modalities – most notably programme aid – to emerge (Mosley and Eeckhout 2000). High profile examples of programme aid include direct budget support, general budget support and sector-wide approaches. Yet while the share of aid disbursed through programme-based modalities has been on the rise since 1970s, projects remain the dominant modality through which ODA is provided (Riddell 2007). In the bulk of cases therefore, what the majority of aid donors are actually championing are mixed aid portfolios, which channel aid through project and programme-based approaches.

While doubts have been raised about the perceived advantages of programme aid (see Mosley and Eeckhout 2000; Rogerson, Hewitt and Waldenberg 2004; Killick 2004; Pronk 2004) - for instance that it can reduce the transaction costs incurred by the recipient country - De Renzio (2005b) reminds us that the shift towards programme modalities has so far failed to make a clear impact and as such, empirical evaluations will have to wait.

Scaling Up Aid and Shifting the Focus to Effectiveness

Following the ‘aid fatigue’ of the 1990s (when disillusionment over aid’s impact led to radical declines in aid giving), the first decade of the new millennium has witnessed the advocacy for aid revitalised by calls for increased, better quality and mutually accountable aid. Such calls have been bolstered by the poor progress of Sub-Saharan Africa toward attaining the MDGs (Commission for Africa 2005; G8 Gleneagles 2005) and by a series of high-level forums aimed at reforming aid management (see box 2). And while such calls aren’t without precedent – the

⁶ Please see Chapter Five for an overview of the GFATM and explanation of the term ‘Conditions Precedent’.

Pearson Report originally called for bilateral aid commitments of 0.7% gross national product in 1969 (Pearson 1969) and Easterly (2002: 49) reminds us of the “historical amnesia” afflicting the aid industry - the forcefulness with which they are now being promoted is unrivalled.

Box 2: High-level Forums Targeting Aid Reform in 21st Century

The Monterrey Consensus of the International Conference on Financing for Development (UN 2002):

At Monterrey, the international community sought to confront the challenges of financing development, and committed once again to reaching the 0.7% GNP target in addition to identifying new funding sources to facilitate scaling up aid. It also laid out eight steps aimed at improving the efficacy of aid.

The Rome Declaration on Harmonisation (Rome High-Level Forum 2003):

Reaffirmed donors' commitment to the *Monterrey Consensus* whilst building on the earlier document's recommendation that donors strive to harmonise their aid delivery in accordance with partner country priorities.

The Paris Declaration on Aid Effectiveness (Paris High-Level Forum 2005)

Reaffirmed the commitments made at *both* Rome and Monterrey, whilst making recommendations to improve aid effectiveness in relation to five key areas:

- Ownership: partner countries exercise effective leadership over their development policies and strategies, and co-ordinate development actions
- Alignment: donors base their overall support on partner countries' national development strategies, institutions and procedures
- Harmonisation: donors' actions are more harmonised, transparent and collectively effective
- Managing for results: managing resources and improving decision-making for results
- Mutual accountability: donors and partners are accountable for development results

The Accra Agenda for Action (Accra High-Level Forum 2008)

Aimed at accelerating the implementation of the Paris Declaration (mid-way) and responding to emerging aid effectiveness issues. The next High-Level Forum will be held in Seoul in 2011

Reminiscent therefore of the “big push” terminology originally progressed by Austrian economist Rosenstein-Rodan (1943), the current emphasis on “scaling up” aid has once again saved ODA from its worst critics (Easterly 2001, 2002, 2006; Erixon 2005; Bauer 1984; Dos Santos 2003; Kanbur 2000), by assigning the earlier failure of aid to bad donor practice. Hence the dominant framing that: “Low-quality assistance has fostered the serious misinterpretation that aid does not work...The

problem is not aid – it is how and when aid has been delivered, to which countries, and in what amounts” (UN Millennium Project 2005: 197).⁷

Scaling Up Aid For Health

In line with ODA’s expanding social remit, it is salient to the focus of this thesis that the impetus for the big aid push has now merged with the consensus that health provision in developing countries needs scaled up (Commission on Macroeconomics and Health 2001). In fact, two earlier shifts have served to solidify this focus. Firstly, the (residual neoliberal) drive towards service privatisation and the subsequent diversification of actors and funding mechanisms within the health sector. Catalysed in the 1980s by general disillusionment with the role of the nation state, the privatisation narrative in health is distinguished by a reassessment of the appropriate role governments should play in the health sector, with the conclusion being that the state’s role should be curbed and markets primed to fill the void (Buse, Mays & Walt 2005). The consequence of neoliberal privatisation has been to encourage a mix of financing mechanisms in developing countries - although as the Commission on Macroeconomics (2001) points out this was a *fait accompli* in such settings anyway - and the growing popularity of public-private partnerships in health. Related to this latter development, a growing trend has emerged for civil society organisations to be used as “public service contractors” (Korten 1990). The second shift has arisen because of the current emphasis on meeting international health targets and in particular those determined by the MDGs.⁸

Remarkably, given concerns in other sectors about the capacity of developing countries to absorb high volumes of aid (De Renzio 2005), absorption is not foreseen as a major problem afflicting health aid, or at least in countries that enjoy good policy environments (Commission on Macroeconomics and Health 2001; the High-

⁷ Jeffrey Sachs, who is one of the main contributors to the UN Millennium Project, continues to campaign on behalf of aid (Sachs 2005). Collier (2007) is another vocal proponent. Riddell is a cautious optimist who nevertheless defends aid on the basis that “The most reasonable default position on the impact of aid is that it should be viewed as helpful, unless it can be shown not to be beneficial, rather than (as frequently occurs at present) it is assumed to be detrimental unless proved to have been effective” (Riddell 2007: 176).

⁸ WHO (2005) underscores that the health focus of the MDGs isn’t just restricted to Goals four, five and six, but is represented in a multitude of targets and indicators contained within each of the eight umbrella goals.

Level Forum on the Health MDGs 2004; Hanson et al. 2003). Moreover, for the not so fortunate, there is widespread agreement that options for healthcare delivery should simply be considered outside the public sector (Commission on Economics and Health 2001; Hanson *et al.* 2003).

In short, in the discourse concerning international development, the health, aid and governance agendas have in recent years been rendered inextricably linked.

Aid Conclusion

To sum up, reinvented and rebranded but never wholly rejected, the case for development aid has been reinvigorated in the Twenty-First Century. Evoking what Emmerij has described as aid's "flight forward," whereby aid has become a permanent feature of international relations by "moving from one priority to the next without solving the preceding one" (Emmerij 2004: 36), as time has progressed, all that has changed are the expectations placed upon ODA (with its remit now encapsulating macroeconomic, social and governance concerns) and the prescriptions over what needs to be done to make it more effective.⁹ That the case for aid remains strong in spite of its complex evolution (and uneven track record) needn't prove problematic as long as you side with the school of development thinking that believes a key purpose of development aid is to experiment: "it has been argued by some aid practitioners that it is inappropriate to expect most aid to be successful, as this misconstrues a key purpose of development aid, namely its experimental nature" (Riddell 2007: 178).

Viewed from this perspective, what is unprecedented about aid's current status is that for the first time in ODA's contested history the majority of aid donors and recipients have ascribed to a *shared* view of the elements that (should) make for an effective aid system - a consensus which Rogerson, Hewitt and Waldenberg (2004) have termed the "Monterrey view."¹⁰ In short, despite the implicit acknowledgement that

⁹ Crewe and Harrison (1998: 15) note that the discourse on reforming development rarely questions the need for the "aid industry" itself.

¹⁰ The key elements in the 'Monterrey view' are: 1) a compact linking sovereign responsibility in developing countries for good governance and development choices with better aid and sharply increased aid volume in developing countries; 2) the MDGs as guidance for country development

the efficacy of new aid initiatives like the Paris Declaration and the Global Health Initiatives are yet to be tested, the majority of interested stakeholders have at least agreed upon the parameters of the experiment.

The Intuitive Force of Coordination

Long before the advent of the Paris Declaration in 2005, the idea that ‘coordination’ might be one way to improve the efficacy of development assistance was toyed with. Cassen (1986) originally touted the idea, which was subsequently picked up by the Organisation for Economic Cooperation and Development Development Assistance Committee (OECD DAC 1992). The OECD DAC established a set of principles related to aid coordination in 1992 which, Buse and Walt (1997) argue, can be extrapolated specifically to health sectors. Predating the sector-wide approach, such principles advocated for donor involvement in sector-wide planning and for the subsequent alignment and harmonisation of development assistance.¹¹ Indeed, it was Buse and Walt who had remarked on the need to pay the health sectors of developing countries special attention in the 1980s and 1990s because of the proliferation of external actors (bilateral, multilateral and non-governmental) involving themselves in that realm. Such an “unruly melange” they argued, had reduced the ability of MoH’s to lead the health process, and contributed to the donor preoccupation to increase the efficacy of development assistance (Buse and Walt 1997; also see Van de Walle and Johnson 1996 who highlight the burden placed on countries with multiple donors and projects; more recently the OECD DAC Task Team on Health as a Tracer Sector has highlighted the importance of dealing with the “fragmentation problem” posed by the

priorities; 3) partnership approaches including the Poverty Reduction Strategy process; d) streamlined conditionality, recognising the failure of conditionality; 5) performance-based aid allocations (Rogerson, Hewitt & Waldenberg 2004: 10).

¹¹ These are as follows: “The ministry of health should take the lead in managing external assistance as part of a national plan of strategy for health development; It behoves donors to provide technical assistance to enable ministries to undertake the critical functions of leadership and planning; All external resources must be deployed within the framework of the plan; Donors need to subvert their administrative constraints, commercial and other interests in pursuit of improving the effectiveness of the health sector as a whole; Bilateral and multilateral agencies should be involved with the government in designing a health plan which reflects a genuine consensus” (Buse and Walt 1997: 454).

proliferation of funding and delivery channels in health (OECD/DAC Working Party on Aid Effectiveness 2009: 12)).

As with the broader aid effectiveness agenda, an empirical grounding to underpin the drive for donors to coordinate in health sectors is notable mostly for its absence (Riddell 2007) - the concept instead being said to hold strong “intuitive force” (Buse and Walt 1997: 449; Walt *et al.* 1999a: 207). Similarly, the underlying logic for coordination mimics that of aid effectiveness, for suggesting that when donors worked in isolation their ODA was largely ineffective, thus the converse may also be true. In this light, it is enlightening to note that initially the intuitive appeal of coordination appeared to reside largely on the side of the development partners in host countries, with governments at best sceptical and at worst, actively resistant (fearing asymmetrical power relations as well as diminished opportunities for playing donors off against each other) (Walt *et al.* 1999a). And while the tension created by early coordination attempts is thought to have been eased somewhat by the onset of the sector-wide approach - which at least in theory assigns ministries of health a leading role in partnership activities - it is pertinent to the long-term impact of the aid effectiveness agenda that the stakeholders in the host country are often less enthused about the newest aid fads than the donors.¹² Hence, the title of this thesis “Prescribing Aid Coordination,” because as is so often the case in development, it is the aid givers rather than the aid recipients who appear to be driving the agenda. Subsequently, the early Walt *et al.* (1999a) finding that none of the coordination instruments they had witnessed in case study countries had excelled – and the reasoning behind that judgement – is a forewarning for what is to come in the Ugandan case material:

¹² For instance at the Mid-term Review of Health Sector Strategic Plan II, held in Kampala between 27th and 29th May 2008, it was remarkable to hear Uganda’s district representatives voicing their dissent over some of the aid practices associated with the Paris Declaration. For example, participants talked about the ‘golden days’ of project aid when districts monopolised project funding in their catchment area, and voiced concerns about donors leaving the health sector as part of the division of labour exercise (the fear being that their aid would go with them). Such comments vindicate the suggestion by Rogerson, Hewitt and Waldenberg (2004) that new aid practices, like budget support, may prove less popular with the general public in donor countries as a consequence of being less tangible than project aid and more vulnerable to the ramifications of poor governance.

“For example, few [coordination instruments] are led by recipient authorities, few embrace all donors active in the sector or a large proportion of aid, few command sufficient authority to ensure participant compliance, and as a result, few actually dramatically enhance the overall effectiveness of aid deployment or ensure that donor contributions support recipient goals. Fourth, it is admittedly difficult to judge the effectiveness or impact of aid coordination...” (Walt *et al.* 1999a: 213).

Indeed this thesis is founded on the idea that although coordination of the type extolled in Paris may not be possible or even desirable, there are nevertheless other reasons why a partial adherence to the ideal may prove attractive to partners.

All five tenets of the aid effectiveness agenda are implicit in the focus of this thesis, yet it is the catchall phrase ‘coordination’ that I use to explore health sector relations in Uganda. There are three reasons for this. Firstly, the coordination activities and fora are the tangible manifestation of the aid effectiveness agenda at the level of the aid recipient country. Thus for instance while a partner may state in their policy discourse that they are engaging in ‘harmonisation’ activities at the country level this is ultimately a subjective viewpoint, (and one with which other partners may or may not agree). On the other hand, the *appearance* of a partner’s involvement in harmonisation activities is much easier to verify from the standpoint of the outsider, by noting for instance what coordination fora they regularly attend or which partnership processes and mechanisms they support (i.e. sector planning, basket funding etc). Secondly, unlike the Paris tenets, ‘coordination’ has not been assigned objective indicators with which to measure progress towards a fixed ideal. Indeed, many of the indicators used in the Paris Declaration would have little to say about the tradition of partnership activities in Uganda’s health sector, which as suggested by Buse and Walt (1997) long predate the advent of Paris in 2005.

To sum up, in my research approach I have been motivated, like Crewe and Harrison, to explore the “messier...but arguably more accurate” view of reality posed by Uganda’s partnership activities - the bits that depend on human relations, and the loaded concepts of ‘partnership’, ‘power’ and ‘participation’ (Crewe and Harrison 1998: 5; also see Sachs 1993; Cooke and Kothari 2001) – which are rarely reflected in cold indicators. Hence I appreciate the usefulness of the term ‘coordination’, as

just one in a long line of slippery development constructs or “master metaphors” (Mosse 2005: 9), subject to interpretation, negotiation and abuse.¹³ Having said that, I am realistic that some boundaries are helpful. Therefore I am grateful to Buse and Walt (1996) who, having noted the absence of a definition to pin down what was implied by ‘coordination’ in relation to a donor-partnered health sector proposed the following working definition in 1996:

“any activities or set of activities, formal or non-formal, at any level, undertaken by recipients in conjunction with donors, individually or collectively, which ensures that external inputs to the health sector enable the health system to function more effectively, and in accordance with local prioritise, over time” (Buse and Walt 1996).

Moreover, I have been greatly influenced by Walt *et al.* (1999a), who had a second go at pinning down the concept of aid coordination in 1999 when they took the practical step of cataloguing the “coordination mechanisms” they had identified in developing health sectors.¹⁴ Indeed, the suggestion implicit to that article - to conceptualise coordination in terms of mechanisms and processes rather than as a single definition – is the most useful way that I have found to approach the concept. Subsequently, it is the mechanisms and processes of partnership between Uganda’s Health Development Partners and the Government of Uganda that constitute the empirical basis of this thesis.

To sum up briefly, while this thesis is specifically looking at aid coordination in Uganda’s health sector, the literature cited in this and the preceding sections of this introductory chapter have been included to show that the Ugandan case study is not operating in a vacuum. Uganda’s health sector should be regarded as an intersection

¹³ Supplant the word “coordination” for “participation” in the following excerpt and you too may begin to understand its appeal: “As a legitimizing idea, ‘participation’ is sufficiently ambiguous to allow many different readings, and several shadow or subordinate models – rationalities validating action from different points of view” (Mosse 2001: 29).

¹⁴ The mechanisms they identified in 1999 were: special units for the coordination of external resources; geographical zoning; groups of donor agencies; appointing a lead donor agency; regular collective consultations between recipients and donors; comprehensive strategies, plans and expenditure programmes; earmarked budget support, pooling and ‘basket’ arrangements; and common procedures for the management of external funds (Walt *et al.* 1999a).

where international thinking over aid and health policy is being actualised. Uganda, in short, continues to be a site of aid's experimentation.

Thesis Structure: Four Propositions About The Reality Of Aid Coordination In Uganda's Health Sector

Having taken an inductive approach to my fieldwork and data analysis, I have been guided by Mosse (2005) in structuring my empirical data around a series of propositions.¹⁵ Subsequently, each of my empirical chapters (Chapters Four to Seven) enjoys an overarching proposition. The chapters when viewed together serve to validate my larger argument, which proceeds as follows: on the surface 'coordination' appears to be important for its internal significance - as an organising principle to improve the effectiveness of aid. Instead, the value of coordination stems from its external significance. Coordination creates a façade of unity which permits the continuance of aid flows to Uganda (evoking Easterly's 2002 "cartel of good intentions" imagery). In this view all partners (government, donors and civil society) are complicit in the framing that ODA to Uganda is at once necessary and effective and its government cooperative and deserving. Yet the stakes in maintaining this framing are getting higher and higher – ironically, as a direct result of the coordination ethos - because as more aid is provided through multilateral arrangements, public/private partnerships, basket funding and joint budget support, the pressure on donors to withdraw ODA *en masse* also grows. This is the tension identified in Uganda, where the state has been praised for its willingness to 'coordinate' with its partners yet increasingly chastised for its refusal to be dictated

¹⁵ In *Cultivating Development: An Ethnography of Aid Policy and Practice*, Mosse structures his book around five propositions which explore the relationship between policy and practice. These are: Proposition 1: Policy primarily functions to mobilise and maintain political support, that is to legitimise rather than orientate practice; Proposition 2: Development interventions are not driven by policy but by the exigencies of organisations and the need to maintain relationships; Proposition 3: Development projects work to maintain themselves as coherent policy ideas (as systems of representation) as well as operational systems; Proposition 4: Projects do not fail; they are failed by wider networks of support and validation; Proposition 5: 'Success' and 'failure' are policy-orientated judgments that obscure project effects (Mosse 2005: 14-19).

to over governance issues. It's the country to watch to see what is most highly valued by donors: the tenets of 'good governance' or the framing of Uganda as aid's success story?

Elucidation on the problematic relations donors are currently facing with the government of Uganda is provided in the subsequent chapter, 'Uganda in the New Millennium: the Litmus Test for Development Aid?' This context chapter begins by cataloguing Uganda's meteoric rise to fame – whereby the country became development's most cited exemplar in the 1990s and early 2000s – before citing the main instances in its downfall during the latter half of the decade. This overview should make clear that it has become harder than ever before for donors to continue to give aid (at current levels) to Uganda in good conscience, yet that - in line with Kanbur's (2000) argument - the aid relationship remains so dysfunctional that it isn't in anybody's interest to punish governance violations.

Following the context chapter, a methodology chapter outlines the mixed method approach taken in this study and details the access problems I encountered while attempting to research development-based organisations in the field.

Subsequently, the four empirical chapters that make up the main bulk of this thesis are laid out as follows.

Chapter Four: 'Coordination to visibly pursue the most readily pick and mix element of the new aid agenda' forwards the proposition that *'coordination' is a slippery development term, which partners can pursue on a partial basis without rejecting the ethos in its entirety. They couldn't pursue meaningful partnership even if they wanted to and they clearly don't. This is reflected in the observation that coordination activities are never legally binding and there are no repercussions for failure to comply. In addition to showing an outward commitment to the aid effectiveness agenda, a partial adherence to the coordination mantra nonetheless confers discrete advantages on partners, meaning the illusions of partnership and homogeneity are worth maintaining.* This chapter initially establishes the formalised nature of

partnership in Uganda's health sector between two obviously heterogeneous groups – the Government of Uganda (GoU) and its Health Development Partners (HDPs) – before outlining where partnership commitments (intended to improve the effectiveness of ODA) have tended to go awry at the country level. The chapter then compares and contrasts the *modi operandi*, aid volumes, development objectives, and headquarter and political restrictions of the donor sub-group of Uganda's HDPs to highlight the obstacles to coordination that exist even within this superficially homogenous grouping, the intention being to shed some light on why coordination between overtly heterogeneous groupings such as donors and government might prove intensely difficult. Having established thereafter that aspects of the coordination ethos can be utilised as if part of a 'pick and mix' check list, the chapter goes on to examine how the HDPs negotiate their differences to attain the semblance of speaking with "one voice" in Uganda's health sector, and what advantages the HDPs glean from maintaining even this façade of unity when facing their government partners.

Chapter Five: 'Coordination to Meet the Current Demands of the Contrary and Risk Averse Global Fund' sets up the proposition that while the Global Fund to Fight AIDS, Tuberculosis and Malaria would maintain that coordination between heterogeneous partners in-country is necessary to put together a participatory and needs-based proposal (which in turn should improve the utilisation and impact of grants), instead *'coordination' is necessary to meet the current demands of the contrary and risk-averse aid instrument, allowing it to justify the continuation of grants to a previously untrustworthy recipient (i.e. the Ugandan Government). All partners have a vested interest in making this happen, in their respective roles as the Fund's contributors and beneficiaries. Nevertheless, the costs now involved in securing GFATM grants has exceeded expectations, placing huge demands on the coordination architecture underpinning the health sector.* This chapter explores the exigencies of developing a country proposal for GFATM Round 8 in Uganda, a country that enjoys a notably strained relationship with the aid instrument following the discovery of grant misappropriation in 2005. The backdrop to this expensive and time consuming endeavour - in which all partner voices must now be represented and

funding success is far from guaranteed - is the reactive policy making and ad hoc growth of the GFATM, which has resulted in widespread confusion over the respective roles of partners and increased procedural complexity for the Fund's applicants. Subsequently, in Uganda it is discovered that the aid coordination architecture is being asked to bend and sway to support the GFATM's current application demands: with Partnership Funds being used to pay for extensive consultations and technical assistance in support of proposal development, and existing Health and HIV/AIDS coordination fora being asked to subsume Country Coordination Mechanism duties. In addition, it is explained that individual partners have incurred 'unfunded mandates' as a result of their involvement with the GFATM. Indeed the effort that now goes into a proposal calls into question the GFATM's original vision to allocate grants according to need. Instead, it seems that an inability to manage risk has resulted in the prioritisation of quality-based rather than needs-based proposal, and introduced the cost of failure (literally the cost incurred when partners invest in failed proposals) to the aid relationship in Uganda. In this view, the Fund's insistence that all partners 'participate' in GFATM processes at the country level in Uganda is actually a device to introduce extra oversight over the use of GFATM grants to prevent a repeat of past abuses.

Chapter Six: 'Coordination to Build Policy Consensus as an Act of Legitimation' proposes that *with aid conditionality out of favour, development partners are drawing on 'coordination' mechanisms and processes to attempt to build consensus around their development strategies to permit the continuance of aid flows to Uganda. In this way policy actually follows practice (Mosse 2004, 2005) as reaching consensus only serves to legitimise what development partners were already doing in the health sector. Indeed a failure to build consensus need not create the impetus to change donor policy, particularly if what you're doing is found to be effective. Instead it is likely that more consensus building is what is really required.* This chapter initially draws on two case studies to highlight how some of Uganda's Health Development Partners – in this case the Danish International Development Agency (Danida) and the World Health Organisation (WHO) - are using coordination techniques to attempt to build policy consensus around their individual agency

objectives. At the same time, the question of whether such techniques can resolve the tension of instilling country ownership when attempting to forward non-indigenous development priorities is considered. Danida and WHO therefore, are found to exhibit the modern aid obsession with *getting policy right* in Uganda's health sector, a preoccupation not currently exhibited by the US President's Emergency Plan for AIDS Relief (PEPFAR). Introducing a third case study, the PEPFAR programme, having assumed ownership of the threat posed by the global AIDS pandemic, is shown to have little interest in influencing Uganda's policy environment at present. Furthermore, in a challenge to the logic underpinning the Paris tenets of ownership, harmonisation and alignment, it is shown to be operating a very successful *parallel* supply chain management system for antiretrovirals, which may have lessons to teach the national procurement system. Yet despite major differences in approach, the backdrop to all three case studies is the heightened competitiveness of the modern aid environment, which determines that funding and seats at the policy table are awarded according to comparative advantage. As such, it becomes clear that Danida and WHO are both under some pressure to legitimise their programmes in Uganda, which they attempt to do by staying relevant in domestic policy. PEPFAR on the other hand - deriving its legitimacy from hitting numerical targets set in Washington and answerable primarily to the US Congress - is not under the same pressure. Nevertheless, the chapter concludes by positing whether the PEPFAR Uganda programme, as it transitions from phase one (the emergency phase) to phase two (which advocates building sustainable, country-driven programmes), might yet be persuaded to develop a penchant for policy.

Chapter Seven: 'Coordination to Dilute State Control' deals with the growing influence being assigned to civil society organisations in Uganda's health sector by the Health Development Partners and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Yet rather than accepting at face value the stated argument that the elevated role currently being assigned to nongovernmental partners stems from a desire to increase the efficiency of public services in a country with limited public sector capacity, the chapter forwards the proposition that *bringing CSOs into the "negotiation process proper"* (Jeppsson 2002: 2059) and channelling aid in such a

way that it bypasses the public sector, is an overt attempt by aid donors to dilute state control in Uganda. This attempt stems from the residual distrust the state created during the neoliberal era and from the logic of ‘good governance’, which like neoliberalism emphasises the developing state’s deficiencies, while also promoting the democratisation of health (GFATM 2008b). The chapter opens by recognising the concessions already made to civil society in Uganda as a result of public sector reform, yet acknowledges how the Ugandan state has until recently been successful in limiting the role of CSOs in the health sector to that of voiceless service providers. Subsequently, the Global Fund is found to be main instigator behind the recent invitation for CSO representatives to join the country’s most important multi-stakeholder coordination forum for health, the Health Policy Advisory Committee. I argue that this has been quietly mandated in GFATM policy discourse, and subsequently formalised in Uganda’s new Long-Term Institutional Arrangements - the blueprints for aid management to have facilitated the restart of GFATM monies to the country following the 2005 mismanagement. Indeed, as the chapter underlines, it was an indigenous CSO worker that turned whistleblower over the GFATM misuse in Uganda, a fact which has since validated the Fund’s view that CSOs are suited to a watchdog role in grant recipient countries. The Global Fund – together with a handful of Uganda’s Health Development Partners – is also involved in spearheading the new Civil Society Fund (CSF) in Uganda, a basket funding mechanism, which, by virtue of the aid harmonisation logic has legitimised Uganda’s donors channelling tens of millions of dollars outside the government budget. Remarkably the operating model of the CSF in Uganda is actually based on a United States Agency for International Development model, highlighting that it is the template of one of the world’s most risk averse bilateral donors that gains credence when it comes to donors pooling their money at the country level. The Civil Society Fund promises to build the capacity of Uganda’s CSOs. Nonetheless, the chapter highlights the dangers posed to CSOs that grow too dependent on donors. The final section of the chapter acknowledges that in order to gain any sway in the “negotiation process proper” (Jeppsson 2002: 2059) in Uganda, CSOs like donors, will have to coordinate themselves in order to get their message across at the Health Policy Advisory Committee. This, it is argued, will not be an easy task for CSOs who are by far the

most heterogeneous of the superficially ‘homogenous’ groupings represented there; moreover, there may be serious pitfalls involved in Uganda’s CSOs having to become ‘representative’. The chapter concludes by issuing two warnings: the first to the civil society organisations, warning them to beware that it is not their influence being diluted by aid coordination measures; the second to donors, reminding them to stay alert to the unintended or “instrument-effects” (Ferguson 1990: 256 citing Foucault 1979) of their efforts to undermine the Ugandan state, which has grown rather adept at negotiating challenges to its dominance.

The thesis concludes by positing that any suggestion to the effect that Uganda’s coordination instruments and processes are not excelling, would be to misunderstand what they are really setting out to do. The conclusion also reaffirms the thesis’s overarching proposition; namely, that coordination is primarily important for its external significance, for maintaining the framing that aid to Uganda is justifiable at current levels.

CHAPTER TWO:

UGANDA IN THE NEW MILLENNIUM: THE LITMUS TEST FOR DEVELOPMENT AID?

The Statistics

Uganda is a land-locked country in East Africa, with a population of 32.7 million (UNFPA 2009: 80) and a per capita income of US \$420 (2008 figures).¹⁶ It is currently rated 157 (of 182) in the Human Development Index (UNDP 2009: 169).

While Uganda has enjoyed significant economic growth since the National Resistance Movement (NRM) came into power in 1986, the fruits of the growth have been allocated unevenly and a widening inequality has been noted in society.¹⁷ Inequality in Ugandan society has long been aggravated by two factors: unchallenged regional inequity and a long-standing war in the north of the country against the rebel faction, the Lord's Resistance Army. As a result of these discrepancies, statistical information that attempts to make generalisations about the country should be regarded critically.

Although the country's health statistics have long been a cause for concern – it remains off course for the Millennium Development Goals (MDGs) and is on target for just three of the eight indicators it has established to monitor progress toward *Health Sector Strategic Plan II* (MoH 2008b: 7 & 9) - a stagnating HIV prevalence rate in the new millennium (6.4%) (UAC 2007: I) and emerging challenges - in the form of rapid population growth (3.3%) and unplanned for urbanisation (4.4% per

¹⁶

<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/UGANDAEXTN/0,,menuPK:374963~pagePK:141132~piPK:141109~theSitePK:374864,00.html> [Accessed 11/03/10]

¹⁷ Uganda's economy grew at an average of 7.2% between 1997/8 and 2000/2001, at an average of 6.8% between 2000/2001 and 2003/04 and at an average of 8% between 2004/5 and 2007/8 (MoFPED 2010: 1).

annum) - are augmenting the difficulty of meeting the country's rapidly escalating health care needs using an already overstretched resource envelop.¹⁸

Uganda's statistics serve to align it with the World Bank's definition of generic Less Developed Country (although it is increasingly on the cusp) which as Ferguson has suggested, establishes it as "a country with all the right deficiencies, the sort that 'development' institutions can easily latch unto" (Ferguson 1990: 70). Indeed, the perceived suitability of Uganda for development's input is aptly demonstrated by the generous aid flows to the country: US \$1005.68 million from Organisation for Economic Cooperation Development Assistance Committee (OECD/DAC) donors alone in 2008.¹⁹ Donors provide approximately 50% of the health budget in Uganda, although that proportion has been greatly skewed in recent years by the emergence of Global Funding Initiatives, such the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI).²⁰ The nature of aid flows to Uganda clearly points to a culture of aid dependency - particularly in the health sector - prompting concerns about the sustainability of current resource flows and the feasibility of Uganda to "graduate" from aid in the foreseeable future.²¹

¹⁸ 6.4% is the figure cited in Uganda's *National HIV & AIDS Strategic Plan* (UAC 2007); however it should be noted that most international bodies are citing a prevalence rate of 5.4% for 15-49 year olds, e.g. UNAIDS. <http://www.unaids.org/en/CountryResponses/Countries/uganda.asp> [Accessed 11/05/10] Uganda's average population growth from 2005 to 2010 is put at 3.3% (UNFPA 2009: 80). Uganda's urban growth rate over the same period is put at 4.5% per annum (UNFPA 2009: 80).

¹⁹ Figure extracted from OECD DAC on 17th May 2010; total ODA from "all donors" to Uganda in 2008 was: US \$1656.76 million. <http://stats.oecd.org/qwids>

²⁰ The official contribution of Development Partners to Uganda's health budget has been found to fluctuate between 46% and 54% of the annual budget as expressed in the Medium-Term Framework (MTEF) (MoFPED 2010: 249). However, donor project funding is not always declared in the MTEF, meaning that once expenditures are taken into account the proportion of donor funds to the health sector escalates. For instance, the *Annual Health Sector Performance Report 2006/7* breaks down expenditure in the health sector for Financial Year 2006/7 as follows "Ug. Shs 239.11bn by GoU, and Ug. Shs. 540.12bn by donor projects" (MoH 2007a: 17). The donor figure here includes expenditure on projects that were not accounted for in the original MTEF. This points not only to a culture of aid dependency in the health sector but also of unaligned and unpredictable donor projects.

²¹ The United States Agency for International Development (USAID) talks about "graduation" from aid as countries attain middle-income status. Although it openly admits "USAID has long found it difficult to formulate a graduation policy..." (USAID 2004: 27).

Box 3: Trend of Financial Support to the Health Sector 2001/02-2008/09 (US\$)²²

Year	Gou Funding	Donor Project	Donor Contribution %	Total	Per Capita (US\$)	Gou Health Expenditure As % Of Total Gou Expenditure
2001/02	169.79	144.07	46	313.86	7.6	8.9
2002/03	195.96	141.96	42	337.92	7.9	9.4
2003/04	2007.8	175.27	46	338.07	8.6	9.6
2004/05	219.56	146.74	40	366.3	8.0	9.7
2005/06	229.86	268.38	54	498.24	9.98	8.9
2006/07	242.63	139.23	36	381.86	7.84	9.3
2007/08	277.36	141.12	34	418.48	8.4	9.0
2008/09	375.46	253.00	40	628.46	10.4	8.3

Uganda: The Archetypal Development Case Example

As established in the introductory chapter, official development assistance (ODA) remains a hotly contested topic; reinvented and rebranded but never wholly rejected, the “aid industry” (Crewe and Harrison 1998: 15) is sustained via ideology and discourse, all of which serve to posit why aid – in its current incarnation - will prove effective this time around. In a specialisation where systematic evidence remains thin on the ground (see Riddell 2007 for an exploration of the evidence base underpinning aid’s impact), case studies of success are rendered invaluable for defending donors’ continued allegiance to development aid. Uganda has therefore proved incredibly important to the industry as a whole: providing enough good newsprint to suggest that aid *surely* works and adding more to development’s technocratic tool kit than any other single country. Indeed, an article to appear in the British press in 2009 aptly summed up the importance of Uganda to the modern development agenda:

²² Source: MoFPED (2010: 250) citing MoH (2008a).

“Alignment; poverty reduction strategies; heavily indebted poor countries (HIPC) debt relief; virtual poverty funds; budget support; public expenditure tracking surveys...few may be aware that all these terms have their origins in a single country – Uganda. Uganda has been one of Africa’s fastest growing economies for the last 20 years and has arguably had more influence on current development thinking than any other country” (Whitworth 2009).

Not simply a passive site for donor experimentation therefore, Uganda has in fact been the vanguard for many of today’s development staples. The government’s first notable innovation, the *Poverty Eradication Action Plan (PEAP)* (MoFPED 1997) may have been renamed by the World Bank but its importance as the blueprint for the now ubiquitous Poverty Reduction Strategy Paper format is universally acknowledged.²³ In the debate that surrounds development aid, it is important to keep in mind that the accoutrements of aid – i.e. the strategies, the guidelines for good practice, the modalities – have evolved to become as important as the resource flows themselves, because it is only by adhering to a (so far) elusive combination of these additives that aid will finally be proved effective. Uganda is one site therefore, that international aid donors watch with interest as they attempt to formulate the perfect recipe.

Conceptualising the Ugandan government as an active contributor to the modern aid agenda is vital when considering the international reputation of the country 13 years on from its original innovation - the 1997 *PEAP* - because in 2010 the Government of Uganda is being publicly reprimanded by its donors. Threats are being made to the country’s substantial aid resources - in this instance in protest to the government’s distinctly lukewarm response to verified instances of high-level corruption (Observer Media Ltd 2010). Moreover, as I will impress, this is not an unprecedented threat but one that has resurfaced with increasing virulence in Uganda since the turn of the millennium.

The Uganda case therefore provides donors with something of a conundrum: donors fell in love with Uganda’s authoritarian and proactive government, buoyed up

²³ See box 1 on p23-24 for an explanation of a Poverty Reduction Strategy Paper.

initially with great returns for their development dollar – impressive economic growth, a falling HIV/AIDS prevalence rates, and a tacit (when the country is *ready*) commitment from the government to the tenets of democracy and good governance – but the realisation has slowly dawned that this forerunner of the aid effectiveness agenda ultimately views itself as the main protagonist in the aid relationship.²⁴ An obsequious or passive recipient of development aid it is not. Uganda’s ambition to evolve into a middle-income country and shake off its faithful donors is tangible in the public statements of the country’s President Yoweri Museveni, who is always on hand to put the aid-givers in their place: “OECD countries must get out of the habit of trying to use aid to dictate the management of our countries... We need independence in decision making. Do they want me to be a slave?” (Vision Reporter 2005).

The central objective of this contextual overview is to frame the subsequent empirical chapters in the following light: Uganda earned itself the moniker of ‘donor darling’ in the early years of the NRM leadership.²⁵ Yet this crown has repeatedly slipped in the new millennium, notably on the occasions when the aspirations of the government and donors have openly diverged. This calls into question what it means to be a ‘donor darling’ in light of the Paris tenet of country ownership, and underscores the requirement for donors to work in partnership with their peers, their governmental and non-governmental partners – i.e. *to coordinate* at the country-level - because simply put, Uganda is a country where the determined supremacy of the government retains the potential to challenge the best efforts of development partners to demonstrate that aid does in fact work.

²⁴ Writing in 2000 (so prior to the country’s 2006 political transition) Russell described Uganda’s President Museveni as a “pragmatic autocrat,” stating that “Museveni is a firm believer that Africa is not ready for multi-party democracy” (Russell 2000: 8 & 282).

²⁵ ‘Donor darling’ is a staple term used by both the media and academia when discussing Uganda’s international reputation. For examples see Cargill (2004), Green (2008) and Eichstaedt (2006).

Winning Favour and Policy Approval: The Making of a Donor Darling

Since the NRM government seized power in 1986, it has solicited international praise for its innovative and participatory approach to policy making. The 1997 *PEAP* is a case in point. In prioritising poverty reduction and laying the foundations for the creation of the Poverty Action Fund (PAF) – a “virtual fund” designed to ring-fence monies for the subset of government departments believed to contribute to poverty reduction (MoFPED 2004: 200) – the *PEAP* enhanced donor confidence that funds would be used to tackle the social determinants of poverty, permitting early donor forays into sector budget support. As Whitworth (2009) has suggested, “Donors loved the *PEAP*.” Quite aside from the poverty reduction focus, which soon became the norm for international development policy post-2000, Uganda’s development partners were also impressed with the extensive public consultation that underpinned the development of the original document, and to which they themselves were invited. The use of widespread consultation in the development of strategic plans (including *PEAP* revisions) is now de rigueur in Uganda, and has contributed to the plethora of coordination fora that serve as the focus of this investigation (see Appendices 1 and 2 for elucidation).²⁶

Several revisions of the 1997 *PEAP* have been released (MoFPED 2000, 2001, 2002, 2004). Of these it is the 2001 revision - *Poverty Eradication Action Plan Volume 3: Building Partnerships to Implement the PEAP* - that deserves special mention, for including a set of ‘Partnership Principles’ intended to guide the government-donor relationship in Uganda (MoFPED 2001).²⁷ The formal and regulated nature of relationship between the Government of Uganda (GoU) and its health donors is an

²⁶ Appendix 1 provides an overview of Uganda’s Development Coordination structure. Appendix 2 depicts an organogram of the official organisational structure of the health sector. While these pictorial representations attest that official coordination groupings have proliferated in Uganda to take advantage of the government’s participatory stance toward its external partners, unfortunately they fail to acknowledge the numerous *unofficial* coordination groupings and networks that also feed into these official structures (for instance, discussion at the National TB Partnership likely filters into policy discussion at the Sector Working Group on Infectious Disease (see Appendix 2)). Unfortunately, the number and diversity of such groupings in Uganda’s health sector mean they can’t be easily be captured in the form of an organisational chart.

²⁷ Please see box 5 for a copy on p96 of the ‘Partnership Principles’.

important backdrop to the coordination narrative in Uganda, the details of which are discussed in Chapter Four. Here, it is enough to note that Uganda's 2001 'Partnership Principles' appear to portend the main tenets of the Paris Declaration on Aid Effectiveness (Paris High-Level Forum 2005) - for instance, making the case for increased budget support - signifying again the influence of the Ugandan case example on the broader development agenda.

As popular as the *PEAP* has been however, the plan's successor heralds a new era in Uganda's developmental approach. Rebranded a *National Development Plan (NDP)*, the new title and theme of the plan - "Growth and Employment and Socio-Economic Transformation for Prosperity" (MoFPED 2010) - reflect a shift in focus that seeks to combine poverty reduction with economic growth.²⁸ A *Concept Note* to precede the release of the new *NDP* suggested this was the logical consequence of certain development opportunities to have emerged in Uganda since the last *PEAP*, which include (among other things): oil discovery and mineral development, the improved integration of the private sector and investment with poverty eradication, (the anticipation of) decreasing aid flows amidst increasing domestic revenue, and the return of peace and security in the Great Lakes region (MoFPED 2007). In short, the message implicit in the *NDP* is that official development assistance (ODA) is expected to play a less important role in the country's future development.

An evaluation looking into the implementation of the Paris Declaration in Uganda suggested that the development of the *NDP* had already represented a trade off for donors – with the GoU choosing to lead the process, thus minimising donor input. As a result, Uganda's development partners had been forced to prioritise their commitment to country ownership over their desire to participate (Office of the Prime Minister 2008: 43). How well they will now support the *NDP* – which doesn't necessarily reflect their objectives to the same extent as the old *PEAP*-format

²⁸ The *NDA* explains that "While the *PEAP* stressed poverty eradication and prioritised social services, the *NDA* maintains the poverty eradication vision, but with an additional emphasis on economic transformation and wealth creation thereby intertwining sustainable economic growth with poverty eradication" (MoFPED 2010: 3).

(Riddell (2007) underscores that for many donors the moral case for ODA centres on its perceived role in poverty reduction) – remains to be seen.

Shifting the focus now to Uganda's health sector, Uganda's 1990's health reforms garnered widespread praise and international attention for the NRM government. These were initiated under *The Constitution of the Republic of Uganda* in 1995, which established the right for all Ugandans to access health services and the compulsion of the state to ensure the provision of basic medical services to the population (GoU 1995: Preamble XIV (iii) & XX). Followed in 1997 by the *Local Government Act* (which established the GoU's policy of decentralisation) and the country's first *PEAP* (MoFPED 1997), Uganda's health focus was fully cemented by the *National Health Policy* (MoH 1999) and *Health Sector Strategic Plan 2000/01-2004/05 (HSSP I)* (MoH 2000).

HSSP I is viewed as an important juncture in GoU policy, for signalling to donors that Uganda was on track with the Sector-Wide Approach (SWAp).²⁹ *HSSP I* established Uganda's Minimum Health Care Package through which "cost effective interventions that are considered to have the highest impact on reducing morbidity and mortality from the major contributors to the disease burden..." are prioritised within the country's limited resource envelope (MoH 2000: 15). It also established the sort of targets – for instance, to reduce infant and maternal mortality rates and to control communicable diseases – that confirmed it as a donor-friendly document, aligned with international targets the Millennium Development Goals (although it omits the actual terminology). The *HSSP I* like the *PEAP*, therefore added weight to the argument that Uganda was increasingly ready to move away from project aid and toward budget support; an intention made explicit in 'Partnership Principle Six' - "donors will continue to increase level of untied sector budget support" (MoFPED 2001: 4).

²⁹ The sector-wide approach (SWAp) in Uganda's health sector was instigated in 2000. For an explanation of what is meant by a SWAp, see box 1 on p23-24.

An updated version of the *HSSP* was released in 2005, and it is *Health Sector Strategic Plan 2005/06-2009/10 (HSSP II)* that currently guides the sector-wide approach in the health sector in 2010.

By establishing targets for the sector and prioritising areas for intervention, the *HSSPs* have served to create a degree of public accountability for healthcare in Uganda that hadn't existed previously. Thus while health indicators haven't been revolutionised during the course of the two medium-term plans, there have at least been targets in place to compare results against and a burgeoning culture of data collection and analysis in the health sector to measure the country's incremental achievements. Moreover the SWAp has meant that all partners acting in the health sector – including nongovernmental partners – are now obliged to consider how their activities contribute to the national framework; with donor projects being subject to government approval. The *HSSP* thus provides an overarching framework for all decentralised and organisation-specific planning in the health sector. That Uganda's Health Development Partners have embraced the health SWAp is evidenced in the increased levels of sector budget support recorded for the health budget each year.

Retaining a health focus, it would not be possible to discuss Uganda's ascendancy to 'donor darling' without addressing what has become the country's biggest claim to fame to date: a country-led HIV/AIDS offensive attributed with a 20% drop in the national prevalence rate (from 30% to 10%) over the course of the 1990s (Parkhurst 2002: 78). In terms of winning international attention and establishing Uganda as a development exemplar, such statistics have proved fundamental. The Ugandan case example remains the most frequently cited in international discourse on the global HIV/AIDS pandemic, with a popular version of the Ugandan narrative proceeding as follows:

"In contrast to governments that ignored the looming [HIV/AIDS] crisis, President Museveni and the NRM government were open about AIDS from the time they won power... While violent predecessor regimes relied upon centralised, corporatist state institutions, the new government fostered a vibrant civil society of voluntary associations... The extent of collaborative social mobilisation is unique in Africa. This exemplary openness created an

enabling context for change, with debate, dialogue and action” (Schoepf 2003: 553-554).

Another important insert at this point is that Uganda originally championed the preventative element of the “prevention, treatment, care” continuum, emphasising all aspects of the ABC (Abstinence, Be Faithful, Condom Use) approach to behavioural-change. That was, until the moralising influence of US foreign policy served to downplay the importance of condom use in the new millennium (Schoepf 2003, 2004; also see <http://www.hrw.org/legacy/campaigns/aids/2005/uganda/> [Accessed 11/03/10]).

Today, the claims made on behalf of Uganda and its HIV/AIDS offensive have been somewhat modified. The revised figures attest that Uganda’s prevalence rate peaked at 18% (rather than 30%) in 1992, and was to be found stagnating at 6.4% in 2007 (UAC 2007: i). Indeed as Parkhurst explains, “Many claims of the success of Uganda in dealing with HIV/AIDS have been predicated on selective pieces of information, which have been falsely presented as representative of the nation as a whole” (Parkhurst 2002: 78). Furthermore, international discourse has tended to overplay the role of the Ugandan government – and its select interventions - when explaining the decline.³⁰ Yet even in spite of the mitigating factors, Uganda’s achievements are to be applauded and no other African country can yet boast a comparable decline in HIV/AIDS (Parkhurst 2002). The intention in mentioning the distorted claims therefore, is to impress how important the Ugandan case study has become for both the discourse on development aid and HIV/AIDS. Interestingly, Parkhurst has attributed the mass acceptance of questionable statistics to ‘donor fatigue’, blaming the political pressure on donors to present an image of success to sustain funding at all costs. This pressure is thought to be so strong in the Ugandan case that “The standard of proof for policy recommendations seems to have been lowered to provide the international community with the African success story it wants, or even needs”

³⁰ It is important to remember that the GoU is but one player in Uganda’s multi-partnered, multi-sectoral HIV/AIDS approach, that individuals can change their behaviour for reasons unrelated to intervention campaigns and that there is a notable time lag in the mathematical models that suggest prevalence rates will come to reflect declines in incidence (Parkhurst 2002). Schoepf weighs in on the issue, noting “What types of preventative action have stimulated the most change [in Uganda], however, is at issue, for there are no data to provide rigorous answers” (Schoepf 2003: 554).

(Parkhurst 2002: 80). Evocative of Mosse's (2005) work on the role of *interpretative communities* in development, I shall consider the resilience of the Ugandan 'success story' toward the end of this chapter. For now it is enough to consider that Uganda receives 10-15% of PEPFAR's funding, despite accounting for just 2-3% of its global targets (Institute of Medicine 2007: 108).

Sadly, Uganda's HIV/AIDS gains are being severely tested in the new millennium as the national HIV/AIDS Partnership is forced to cope with new challenges. The 6.4% prevalence rate is publicly referred to as 'stagnating' but the real concern is that it is actually on the rise.³¹ This is partly blamed on the changing nature of the epidemic in Uganda, uncapped population growth and the de-emphasis of the prevention prong of the three-pronged approach in recent years, in favour of treatment. While prevention is now being re-emphasised in the national strategy (UAC 2007), the lingering influence of the USA's last conservative government is still being felt in the inflexibility of the earmarked PEPFAR programme - which funds a large proportion of the national response in Uganda - and which continues to prioritise treatment and promote abstinence-only projects.

A final and unexpected blow to Uganda's reputation for HIV/AIDS came in the form of this off-the-cuff comment by President Museveni in 2007: "To die of Aids is treason. Because you would have betrayed your family, which had invested in you and had hope that you would help them...Instead of being an asset you become a burden...is that not treason?" (Butagira and Kibuuka 2007). Prompting an instant rebuttal from the once Assistant US Global AIDS Coordinator - Jimmy Kolker - (Medical News Today 2007) the statement evoked widespread exasperation and embarrassment in country.

To conclude this section, Uganda's reputation as 'donor darling' has largely resulted from its government's innovative policy-making and openness to working with

³¹ The *National HIV/AIDS Strategic Plan 2007/8-2011/2012: Moving toward Universal Access* notes that "The third phase of the Uganda HIV epidemic (since 2000) has been characterized by stabilisation of HIV prevalence ranging between 6-7%. However, there are anecdotal indications...of an apparent increase in HIV prevalence and incidence during the last few years" (UAC 2007: 1).

external partners. Moreover by its reduction of its HIV/AIDS prevalence rate and an impressive track record of growth in gross domestic product (GDP).

The Centrality of Good Governance: Uganda's Slipping Crown

Turning now to an issue at the crux of the aid effectiveness agenda, that of 'good governance', a quick glance at Uganda in 2010 – which boasts a system of multiparty politics and various institutions dedicated to tackling corruption - would also suggest that the country is in line with the aspirations of its development partners.³² In this respect however, a cursory look would not suffice, disguising the fact that the GoU and its development partners have been in battle for the best part of a decade over what 'good governance' looks like in Uganda.

Indicative of the mission creep inherent to development organisations, donors have come to view domestic politics as another area suited to their input.³³ While the logic behind this encroachment is commonly held to be the Dollar and Burnside (1997) argument – that aid is most effective in a good policy environment (an idea readily embraced and exported by the World Bank (World Bank 1998; Kaufman *et al.* 1999) - there remains no universal definition for what 'good governance' is. The indicators to measure the phenomenon are multitudinous and vary wildly, with the only tacit agreement being that 'good governance' now constitutes something of a global public good. Kapur and Webb (2000) have called it "a matter of interpretation;" Hyden and Court have described it as a "catch-all concept" (Hyden & Court 2002: 12). Such statements therefore, draw natural comparisons with this excerpt from George Orwell's *Politics and the English Language*:

³² In addition to its judicial system, Uganda boasts the Inspectorate of Government and the Office of the Auditor General. A dedicated Anti-Corruption Division of the Ugandan High Court also exists.

³³ While the term "mission creep" was traditionally associated with military operations – denoting the gradual expansion of a mission beyond its original objectives – it has since been used in relation to development, most often in reference to the do-everything approach of donors. Thus while donors were originally focused on providing aid for its perceived macroeconomic benefits, they have since diversified their remit, increasingly targeting ODA at social and governance issues in aid-recipient countries.

“In the case of a word like *democracy*, not only is there no agreed definition, but the attempt to make one is resisted from all sides. It is almost universally felt that when we call a country democratic we are praising it: consequently the defenders of every kind of regime claim it is a democracy, and fear that they might have to stop using the word if it were tied down to any one meaning.” (Orwell 1946: 3)

In Uganda therefore, the dispute between the government and its donors is more often than not a dispute over definition, over what constitutes ‘good governance’ and indeed what constitutes ‘democracy.’ So much so that even when a disagreement appears to centre on corruption it still harks back to governance, because as the World Bank has established, corruption is to be viewed as an outcome of poor governance rather than as a component of it (World Bank 2006). Needless to say, the issue is a sensitive one in Uganda, where the government and its outspoken President are resolutely averse to perceived challenges to national sovereignty. Governance therefore represents the complicating factor in the international community’s relationship with Uganda, and is the issue threatening the country’s crown as ‘donor darling’. The main incidents in the souring of the relationship are recounted below.

Donors have been growing progressively wary of the political climate in Uganda since the turn of the Millennium, with Museveni’s Presidency being perceived as increasingly authoritarian. Tensions first bubbled over in 2002 when the GoU cut the budget of several departments to increase its defence allotment. In protest, donors from the UK, the Netherlands and Ireland withheld development aid. Undeterred, in 2003 Uganda’s defence budget grew by a further 29%. Subsequently, in 2004 the USA deleted Uganda from a US \$7 billion multi-country aid programme citing concerns over human rights and governance issues (Atoo 2005).

Disagreements between the Ugandan government and its donors finally came to a head in 2005 as concerns about the political transition in Uganda - from the ‘Movement system’ to multiparty politics and project *Kisanja* (i.e. the ‘third term issue’ whereby Uganda’s constitution was amended to remove Presidential term

limits allowing Museveni to run for a third term in 2006) - impelled donors to take a public stance.³⁴

Writing in May 2005, Atoo (2005) provided a commentary on the political situation in Uganda at that time. Her account noted that in the preceding months donors had expressed concerns over the following issues: the constitutional amendment, the slow transition to multiparty politics, the alarming increase in foreign debt and the attack on the political opposition. Atoo underlined that concerns were quickly translating into threats to withhold aid; and indeed around that time, Ireland announced its decision to withdraw 2 million Euros from its Uganda programme over the failure of the NRM government to implement political reform (O'Farrell 2005).

In addition, Atoo highlighted the publication of two reports that served to document the concerns of the country's international donors at that time: the OECD's *Africa's Economic Outlook 2004/5* (OECD 2005) and the confidential World Bank document: *The Political Economy of Uganda: The Art of Managing a Donor Financed Neo-Patrimonial State* (Barkan *et al.* 2004). The former suggested that Uganda's economic success was largely due to its high aid levels and warned its handling of the 2006 general election could put these at risk. In addition, it highlighted some of the institutional weaknesses stifling growth in the country and the increasing debt disturbing donors. Finally, it remarked on some perceived improvements in governance in the country but stressed that corruption was still a major problem and had driven up the costs of public sector investment. The latter report, while leaked, remains ostensibly confidential. It is helpful therefore that its primary author, Joel Barkan, published his own paper shortly after the World Bank publication, which I anticipate mirrors many of the concerns expressed in the original.

Barkan's article 'An African "Success" Past Its Prime' (2005) argues that "Once hailed as a compelling 'success story' of Africa, Uganda today is at risk of becoming

³⁴ "The Movement system was originally conceived as a competitive political system within a 'no-party' or non-partisan framework – i.e. the NRM was *not* a party in the political sense, but rather a 'big tent' to which all Ugandans belonged and within which all could compete on the basis of their own 'individual merit' rather than on the basis of their party affiliations" (Barkan 2005: 12). Current indications are that Museveni will run for fourth term in 2011 (Mwanguhya 2007).

another African tragedy” (Barkan 2005: 9). Writing one month prior to the country’s referendum on the decision to return to multiparty politics, he determined that it was Uganda’s continued failure to complete the process of democratisation that was putting its reputation in jeopardy. Moreover, he held the country’s high aid levels responsible for financing the downfall - “aid flows totalling \$690 million per annum...now provides roughly 51 percent of Uganda’s budget, making the country one of the most aid-dependent in Africa” (Barkan 2005: 10) – maintaining that donors were providing the means for the National Resistance Movement (NRM) regime to stay in power.

Barkan highlighted three main areas of concern in the country at that time: the transition to multiparty politics and the repeal of presidential term limits, the war in northern Uganda, and corruption. Addressing the issue of most concern to donors, Barkan outlined how the combination of a return to multiparty politics and the third term issue had split the ruling party, leaving Museveni with a government dominated by less talented ‘yes men’. Furthermore, he suggested that support for the third term issue had been achieved through bribes and force, leading him to anticipate either the threat of repression or insurgency in the run up to the 2006 elections. In conclusion therefore, Barkan judged that “After an extended period of political liberalization...Uganda has slipped back into a period of neo-patrimonial, or ‘big man’ rule” (Barkan 2005: 11).

Discussing the continued instability in northern Uganda, Barkan argued that the war with the Lord’s Resistance Army had *in part* been allowed to continue because it has served Museveni’s political purposes: by helping him to secure power in Buganda, by providing him with an army patronage network that has bought him support and protection, and by muting donor criticism over the slowing of the democratic transition and the third term issue as long as the Uganda’s People Defence Force were seen to be seriously engaged in the conflict.

Finally, on the issue of what he termed “corruption for the purposes of regime maintenance,” Barkan reminded donors of their own role in Uganda’s governance

problems, as he claimed that the high levels of aid provided in budget support directly and indirectly financed corruption in the country and removed the incentive for Uganda to balance its books (Barkan 2005: 19).

In his conclusion, Barkan impressed that Uganda was *not yet* a failed state and challenged its donors to stop denying the reality of what was happening, saying:

“ Having celebrated Uganda’s success, the United States and the rest of the donor community should now acknowledge that the Museveni government is an increasingly corrupt and authoritarian regime that has probably overstayed its welcome. It should also be acknowledged that the current volume of aid, through budget support in particular, sustains this situation” (Barkan 2005: 23).

Ruhakana Rugunda, Uganda’s then Minister for Internal Affairs was quick to refute Barkan’s depiction of Uganda as a success story past its prime (Rugunda 2005). In defence of the repeal of the constitution to allow President Museveni to run for a third term he underscored that “We proposed the removal of term limits as a principle and not for President Museveni” (Rugunda 2005: 32). In addition, in his defence of Uganda’s political state of affairs, Rugunda highlighted some of the indiscrepancies in what donors demanded of partner countries and what they did in practice, positing, “If no term limits bring good governance in Britain, where Tony Blair has just been elected to a third term, why should it bring chaos in Uganda?” (Rugunda 2005: 33-34).³⁵ Finally, he argued that what Uganda wanted was access to global markets - not aid – echoing both an earlier exhortation made by the President (New Vision 27th May 2005) and a widespread anti-aid sentiment that resurfaces with surprising regularity in the Ugandan press.³⁶

³⁵ In November 2007, President Museveni was similarly asked to pass comment on the removal of Presidential term limits as Uganda hosted the Commonwealth Heads of Government Meeting, responding, “You know countries like Britain don’t have term limits. I don’t know whether I should call you undemocratic.” <http://www.ugenda.com/20071124111/Latest-News/Term-limits-are-a-question-of-history-or-convenience-MUSEVENI.html> [Accessed 03/07/10]

³⁶ Just a few examples of stories with an anti-aid overtone to appear in the Ugandan press during fieldwork included: ‘Mwanda, Museveni, Muhwezi: Whence the IGG?’ suggested: “The only people not yet indicted for gross negligence [in the trial over lost GAVI funds] would be the donors writing cheques for monies used so irresponsibly” (Ssemogerere 2007); ‘Africa must discard the begging bowl’ (Sankore 2007); ‘G8 making the wrong diagnosis for Africa’: comments on the futility of foreign aid (Byaruhanga 2007); ‘Africa needs stronger Parliaments’: reports that foreign aid may have weakened democracy in Africa making parliaments less accountable to their citizens (Reuters 2008).

With hindsight one can determine that several of the concerns raised by Barkan in his 2005 publication did not materialise. The July 2005 referendum on the return to multiparty politics and the March 2006 election took place with minimal disruption. Yet today there's talk of a fourth term for Museveni, with a credible alternative seemingly lacking within the NRM or opposition parties. Indeed of his retirement, Museveni has said "A good fighter doesn't retire in the middle of the struggle" (Mukasa 2007). Moreover, the NRM's internal definition of democracy evokes concern when its figurehead makes comments such as this "We would not allow bad leaders who kill people to be in control. If you did not elect us in 1996 and had not given us the mandate, we would have gone back to the bush to fight" (Matsiko 2007). In short, the enduring appeal of the war mentality within Uganda's ruling party remains a concern for donors.

While Barkan's fears over the democratic transition failed to materialise in 2005, his concerns over corruption were amply validated that year, as it was discovered that Ugandan Shillings (USH) 3.2 billion of Global Fund to Fight AIDS, TB and Malaria (GFATM) monies (Mugisa and Nsambu 2009) and USH 1.6 billion of Global Alliance for Vaccines and Immunisation (GAVI) monies (Afedraru 2008) had been misappropriated in Uganda's health sector.³⁷

It is significant that it was money from two performance-based Global Health Initiatives (GHIs) that went awry in Uganda, calling into question both the logic of providing such huge injections of cash to a country with weak institutional capacity, and the manner in which more traditional health aid – not so stringently monitored – may have also been mishandled in the past. Without question the revelations have, and continue to be a public relations disaster for Uganda (and for the GHIs), and not

Another story to have captured a lot of headlines during 2007 concerned the expiration of life-saving drugs at the National Medical Stores (NMS), which certain donors had left in store (using NMS as a third-party procurement agent) but had failed to distribute; this sparked off a wave of vitriol against the guilty health donors: 'Shs3.6b malaria, ARV drugs rot in NMS' (Nandutu 2007a); 'ARVs worth sh1b to be destroyed' (Basudde 2007); 'Drugs scarce yet stocks expire at Medical Stores' (Nandutu 2007b).

³⁷ Converting these figures into dollars, US 1.5 million of GFATM grants and US \$750,000 of GAVI funds were unaccounted for (using currency conversion site: <http://coinmill.com> on 20/03/10).

just because of the widespread corruption that they exposed in the country's health sector (and the loopholes in the GHI's approach).³⁸ Five years on from the revelations, the GHI cases have called into question both the GoU's ability and commitment to hold the alleged embezzlers to account. Put simply, if corruption is to some extent tolerable within the aid relationship (and in conjunction with the 'good governance' agenda), outright impunity is not. This logic is played out in the case of the GFATM mismanagement, which has proceeded as follows.

When missing GFATM monies were exposed in August 2005, the GFATM immediately suspended its grants to Uganda until suitable interim arrangement could be made. Subsequently the funds were restarted in November 2005 using parallel, nongovernmental arrangements. The GoU then initiated an extensive consultation (inclusive of donors and civil society partners) to devise a new way to manage future grants. The resultant Long-Term Institutional Arrangements (LTIAs) were finalised and accepted by the GFATM Secretariat in 2007 and now guide all aid-centric aid relations in the country.³⁹ In so far as restarting the flow of GFATM monies and working to rebuild GFATM confidence therefore, Uganda was quickly back on track following the 2005 revelations. Where it remains off track however, is in its bid to secure prosecutions for those implicated in the GFATM embezzlement. Given that 373 people were originally implicated in the mismanagement – including the country's Health Minister of the time - it is a poor reflection of the GoU's commitment to countering corruption that just two of the cases had made it to the High Court by April 2009 (Mugisa and Nsambu 2009). Moreover, the sheer number of people implicated at every level of the mismanagement appears to point to an ingrained culture of small-scale fraud throughout the public administration.

The snail's pace of the GFATM prosecutions is surprising when you consider that shortly after the scandal broke, President Museveni appointed a judicial commission to investigate the alleged mismanagement, determined to show that "Uganda would use all its might to root out corruption in the use of money and punish wrongdoers"

³⁸ Cohen (2008) underscores that it wasn't the GFATM that discovered the corruption in Uganda, but rather a whistleblower from civil society organisation Aidspace.

³⁹ The LTIAs are explained and feature heavily in the empirical chapters in this thesis.

(Cohen 2008: 522). The output of that commission was the *Ogoola Report*, which catalogued the widespread misuse of GFATM monies between 2003 and 2005. Subsequently, the GoU issued a White Paper in November 2006, outlining its agreement with the majority of the commission's findings and demanding both the repayment of US \$1.6 million and rapid prosecutions. The GFATM Secretariat, it appears, was initially rather pleased with the GoU's response, with the then Executive Director of the GFATM, Richard Feachem quoted in the press as saying "The openness and thoroughness with which President Museveni addressed the Global Fund's concerns...has set an example for how allegations of corruption should be managed" (GFATM 2006b). In short, in the immediate aftermath of the scandal, the government made all the right noises. Following that period however, quite literally "nothing happened" (Cohen 200: 522).



Figure 1: Cartoon highlighting pressure from Uganda's donors that misappropriated GFATM funds be returned (Daily Monitor, 27th May 2008, p34)

In July 2007, the national committee set up to investigate the GFATM abuse reported having no money to pursue the investigations (Hussein Bogere 2007). This eventually led to open criticism of the GoU approach from within the ranks of its development partners, with the Danish Ambassador declaring the GFATM case a “litmus test” for how serious the GoU - and the GFATM - were about tackling corruption (cited in Cohen 2008: 522). A subsequent visit by the Inspector General of the GFATM to assess the progress of the prosecutions in May 2008 confirmed growing frustrations within the donor community (Comment 2008), the allusion being that continued inertia over the GFATM mismanagement was making it harder for every donor to give aid in good conscience.

The GFATM case was given a kick-start in 2008, with the appointment of a new GFATM Inspector General and some assistance from the European Anti-Fraud Office and the UK’s Serious Fraud Office (Serious Fraud Office 2009). Money to advance the prosecutions has now been released by the Ministry of Finance and an Anti-Corruption division of the Ugandan High Court has been established. After a slow start therefore, the prosecutions over the GFATM embezzlement have begun. Now it only remains to be seen how many prosecutions will be secured and whether the damage caused to international relations during the delay can be repaired. Looking at the manner in which the GAVI case has proceeded, however, the GoU is not out of the woods yet.

The GAVI case was originally construed as a much more straightforward case than the GFATM one. Without the need for a commission or a report, 57 alleged perpetrators were quickly identified and trial proceedings initiated (Mugisa, Ariko and Anyoli 2007). Several of the higher-profile suspects in the GAVI case are also implicated in the GFATM mismanagement, and it was initially quite reassuring that their cases were brought to court first (in July 2007). That said, something strange is afoot with the GAVI trial. Recurrent disputes over procedural issues – instigated in almost every instance by the high-profile defendants – have caused multiple adjournments and postponements, meaning it is not now clear whether the case will ever reach completion. Of the accused, it is the former health minister Jim Muhwezi

– former confidant to the President and the man cited as “politically responsible and accountable for the overall mismanagement of the [GFATM] project” (Mugisa and Nsambu 2009) - whose possible impunity poses the greatest threat to Uganda’s reputation for upholding the rule of law. Accusations of political interference, and worse nepotism, would be the natural consequence of his acquittal.

The issue of corruption remains at the top of the agenda for Uganda’s donors and it was continued concern over impunity in the face of corruption that prompted the country’s Local Development Partners Group to issue this warning to the Government in February 2010 (in a statement picked up by the national and international press (e.g. Ford 2010)):

“The Government’s failure to act on high level corruption will have implications, and donors under the Joint Budget Support Framework are currently considering a range of actions. This may include withholding disbursements, reductions in aid, or re-programming away from direct budget support etc...we would like to assure the government of Uganda that Development Cooperation will increasingly be a results-orientated partnership, where development partners can demonstrate to their own taxpayers money is well spent” (Observer Media Ltd 2010).

To sum up, while some of Uganda’s donors have individually threatened to, and on occasions, cut aid to the GoU since the turn of the Millennium, by 2010 a coordination grouping known as the Local Development Partners Group had clubbed together to read it the riot act.⁴⁰ This points to the literal fulfilment of a fear identified within the higher echelons of Uganda’s political leadership several years ago - that budget support has emerged “not only as a ‘carrot’ for good governance, but also a ‘stick’ in the event of poor performance” (Office of the Prime Minister 2008: 47). It also points to another undisclosed property of the aid effectiveness agenda – that of strength in numbers - as the implications of donors’ threats to withhold aid have increased in correlation with their commitment to the Paris principle of harmonisation (an issue addressed in Chapter Four).

⁴⁰ See Appendices 1 and 3 for more information on the Local Development Partners Group and its positioning in Uganda’s coordination architecture.

Box 4: Uganda's Falling Governance Rankings.⁴¹

YEAR	UGANDA'S RANKING IN TRANSPARENCY INTERNATIONAL'S CORRUPTIONS PERCEPTIONS INDEX <i>(Note: the <u>higher</u> the number the worse the ranking)</i>	UGANDA'S RANKING IN THE FAILED STATES INDEX <i>(Note: The <u>lower</u> the number the worse the ranking)</i>
2001	88 (out of 91)	
2002	93 (out of 102)	
2003	113 (out of 133)	
2004	102 (out of 145)	
2005	117 (out of 158)	27 (out of 76)
2006	105 (out of 163)	21 (out of 146)
2007	111 (out of 179)	15 (out of 177)
2008	126 (out of 180)	16 (out of 177)
2009	130 (out of 180)	21 (out of 177)

So far this discussion has pointed to several of the more serious incidents to threaten Uganda's reputation as 'donor darling' since the turn of the millennium. The list it should be said is far from exhaustive. Other questionable events to tarnish the government's reputation abroad have included the inability to account for US \$27 million in relation to the country's hosting of the Commonwealth Heads of Government Meeting in 2007, the appointment of First Lady Janet Museveni as a member of cabinet, the continued heavy-handedness of Uganda's law enforcers in the event of public protest, and the proposed Anti-Homosexuality Bill, which, if passed, could make homosexuality punishable by a life sentence or even death in Uganda. The latter issue in particular has prompted international outrage, prompting President Museveni to exclaim, "Prime Minister Gordon Brown came to see me and what was he talking about? Gays. Mrs Clinton rang me. What was she talking about? Gays" (BBC News 2010). Indeed, the heated reaction of the international community

⁴¹ Sources: http://www.transparency.org/policy_research/surveys_indices/cpi/2009 and http://www.fundforpeace.org/web/index.php?option=com_content&task=view&id=99&Itemid=323 (both accessed on 17/05/10).

to a proposed piece of domestic legislation in a relatively small African country reinforces just how important Uganda remains for the defence of development aid.

To conclude this section detailing the issues threatening Uganda's crown as 'donor darling', let it be made clear, it is the country's donors who – whilst coupling punishment with diplomacy - are working hardest to prevent the crown falling. While the threats have amplified over the years, there has been as yet no ultimatum. Moreover there is little indication to suggest that the Ugandan government is unduly concerned by the political posturing, a position well explained by De Renzio's (2006) theory on the "primacy of domestic policies."

De Renzio highlights the fragility of Uganda's earlier good governance commitments when challenged by the primacy of domestic politics and advises donors that since aid will not prove a powerful bargaining chip, they need to deal with the reality that domestic politics take precedence in recipient country affairs and assume a humbler approach.⁴² If you accept this argument, then you can see that donors are facing something of a conundrum in Uganda. Firstly, although the evidence belies the ability of aid to buy policy (Burnside and Dollar 1997), the main tool at donors' disposal remains ODA. And while the Paris Declaration extols the principle of national ownership, donors don't want to be seen to support a belligerent and/or corrupt government. Finally, to follow through on the threat to withdraw aid to Uganda would be to lose development's exemplar - the case example most readily used to justify the continuation of aid in less amenable environments.

It is helpful therefore that donors have another, lesser publicised tool at their disposal, which allows them to circumvent all the tricky variables that make aid hard to justify in an aid recipient country that just won't tow the line: framing. Mosse (2005) referred to this when he identified the role of interpretative communities in

⁴² "This is a clear indication that whatever donors think or do, in many cases domestic politics takes precedence when power-holders feel that their regimes are being questioned. Donor pressures and threats to cut aid are less important than internal control over the levers of power, especially in countries with weak democratic institutions and traditions." (De Renzio 2006: 1)

determining the success or failure of development projects.⁴³ Easterly (2002) pre-empted it when he likened the development industry to a “cartel of good intentions.”

Conclusion

During fieldwork, a story to appear in the Ugandan press commented on the tabloid claim that President Museveni has just two pictures on the wall of his office, one of himself and one of Zimbabwean President, Robert Mugabe (Ruzindana 2007). The truth or otherwise of the claim isn't important. Instead it's the insinuation that Museveni's style of leadership has on (any) occasion evoked that of Mugabe that's of interest in this - a conclusion interested in the idea of framing. In the run up to the Commonwealth Heads of Government Meeting (CHOGM) in Uganda, a related article appeared in the Ugandan press, publicising the “CHOGM Paradox” by which the north readily praised CHOGM host Museveni while damning Mugabe, despite the two boasting similar paths to power and comparable leadership styles (at least in the opinion of the writer). The author explained the paradoxical framings of the two African leaders as follows “Where President Museveni distances himself from Mugabe is in the way he understands and ably deals with the dynamics of international relations” (Sengoba 2007). There are two points one can infer from this story. Firstly, that Museveni-Mugabe comparisons - which appear quite innocuously in the Ugandan press – would be actively avoided in development discourse, which seeks to frame Museveni in a manner that justifies the continuation of aid flows to Uganda. Secondly, that Museveni (as head of ruling party, the NRM) is cognisant of, and complicit in the development community's framing, doing just enough to make it possible for donors to continue with the status quo. Thus while Museveni may balk at international interference in a piece of domestic legislation such as the Anti-Homosexuality Bill, he will nevertheless take the call when Mrs Clinton or Mr

⁴³ Mosse has underscored the importance of *interpretative communities* in development, whereby “the more interests that are tied up with their particular interpretations the more stable and dominant development policy models become” (Mosse 2005: 8).

Brown phones up to complain.⁴⁴ And when money goes missing from a huge GHI like the GFATM, he will send out the clarion call while the cameras roll even if the momentum for action is fleeting. Through their work *Development Brokers and Translators* Lewis and Mosse (2006) have helped to shed some light on such contradictory behaviour. Subsequently, rather than inhabiting binary roles as tyrants or victims, Museveni and the GoU should be depicted as skilled aid “brokers,” who inhabit shifting positions to deal with the “multiple rationalities of development” (Mosse & Lewis: 15).⁴⁵ Viewed in this manner, the behaviour soon appears quite rational, as the GoU strives to appear strong in front of its people (it won’t be dictated to by external parties) while speaking the language of partnership with its donors (to maintain the flow of aid the country needs). This is certainly not a scenario peculiar to Uganda, but to aid relationships everywhere.

The Uganda case study underlines the symbiotic relationship that exists between donors and their recipients (and validates Kanbur’s (2000) argument that it isn’t in donors’ interests to punish governance violations). It also points to the wider relevance of coordination and harmonisation principles in the aid relationship, because while the crown may have slipped in Uganda, it is clear that donors are not yet ready to denounce Uganda’s status as aid’s success story. Furthermore, Uganda’s ruling party remains willing to do its part (although just enough and no more) to render such a framing plausible. Put bluntly, Uganda’s earlier successes and role in the making of the modern development agenda has rendered it too important to sacrifice. Thus while Barkan determined Uganda to be the “Africa test” for American foreign policy back in 2005, I would elevate its significance further, arguing that in 2010 - in view of the high levels of development assistance awarded the country over the last twenty years and its tentative advances toward establishing a liberal

⁴⁴ This excerpt from Museveni’s 12th May 2006 swearing in speech suggests that he might not have appreciated the phone calls: “Surrendering of sovereignty on decision-making is a very big mistake. I want to assure Ugandans that such mistakes will never occur again under the leadership of the NRM.” <http://www.statehouse.go.ug/news.detail.php?newsId=860&category=News%20Release> [Accessed 11/03/10].

⁴⁵ The complementary yet equally contradictory roles inhabited by donors according to this logic are those of development “translators,” whereby donors help to stabilise the representations of development projects through a process of “translation” that permits the negotiation of common meanings and definitions and the mutual enrolment and co-option into individual and collective objectives and activities” (Mosse and Lewis 2006: 14).

democracy - Uganda has emerged as the litmus test for development aid in general.⁴⁶
It is the case example that most seriously threatens to overthrow current thinking on the dynamics of aid, governance and development in practice.

⁴⁶ “Uganda presents the Bush Administration with the ‘Africa test’ of its announced policy of promoting freedom and democracy around the world. If the Administration cannot pass the test here, where is the policy credible?” (Barkan 2005: 23).

CHAPTER THREE:

METHODOLOGY

Taking a Mixed Methods Approach

This thesis aligns itself with a growing body of ethnographic research that concerns itself with *how* development works (Mosse 2005), and yet it is not itself an ethnographic piece of work. The distinction needs to be made, because while the mixed methodological approach adopted for this thesis drew on a number of qualitative methods readily found in the ethnographic tool box - in-depth interview, discourse analysis, naturalistic observation and triangulation - and while the tight knit aid community encircling Uganda's health sector could well be considered a suitable target for an ethnographic study (a relatively small group of informants in a naturally occurring setting (Brewer 2000)), the tangible barriers precluding 'outsiders' gaining sustained access to what is, at present, a gated community, prevented me from securing the degree of engagement required for a full ethnography. Furthermore, coming as I do from a multidisciplinary background – Arts and Social Sciences – and being situated in the multidisciplinary department of African Studies, it was logical that I would draw on a number of disciplines when designing and conducting my research, in this instance: African Studies, Development Studies, Health Policy, Aid Policy and Anthropology. To sum up therefore, this thesis drew on a mixed methods - and largely - qualitative approach, although some quantitative methods were also used to establish patterns of donor giving to Uganda's health sector.

That said, while this thesis doesn't constitute ethnography per se, it does nevertheless share a common objective with that methodology: "to understand the social meanings and activities of people in a given field..." (Brewer 2000: 11).

Furthermore, as previously documented in Chapter One, the thesis has been heavily influenced by several of the more prominent ethnographies of aid and development to have emerged over the last 30 years. Such ethnographies have a lot to teach the researcher of development based organisations, encouraging a critical approach

which, for instance, refuses to accept discourse at its word - considering instead in a Foucauldian manner what discourse *does*.⁴⁷

Whilst accepting that Ferguson (1990) and Escobar (1995) laid the foundations for the type of study I have attempted with this thesis, I align my thinking with the more nuanced understanding of the modern aid relationship championed by Crewe and Harrison (1998) and Mosse (2005), which rejects both the dichotomous ‘them’ and ‘us’ view championed by the original ‘deconstructors of development’ and the automacity of the machine inferred by Ferguson. In this way, my research is founded on a desire to “to reinstate the complex agency of actors in development at every level...as well as to revise the false notion of all-powerful Western development institutions” (Mosse 2005: 6); this necessitates “examining the ‘interface’ between many groups and actors...” (Crewe and Harrison 1998:19).

Also from this school of development critique, the approach taken for my thesis takes as a given the disjuncture between policy and practice, acknowledging like Mosse that practice doesn’t follow from policy yet that this need not be problematic so long as the “interpretative communities” that sustain stable development policy models function efficiently (Mosse 2005: 8). Moreover that such disjuncture allows for the emergence of “unintended yet instrumental elements” (Ferguson 1990: 21; Foucault 1979). This stance stems from a belief that development organisations actually wield limited operational control over practice (Mosse 2005) and indeed often overestimate their importance in the field (Ferguson and Crewe 1998).

In sum, the methodological approach adopted for this study aligns with the “messier” but arguably “more accurate” view of development reality forwarded by Crewe and Harrison (1998: 5), which as I will argue is sustained at the country-level in Uganda’s health sector via negotiation and compromise, unwritten rules of engagement and fluid alliances between the heterogeneous stakeholders.

⁴⁷ Ferguson considers the function of discourse in light of Foucault’s (1971, 1973) idea of a conceptual “apparatus,” considering it as an elaborate contraption which *does* something and which has its own effects that go beyond concealing the true intention of development projects.

A Brief Introduction to the Research Topic

The research topic is concerned with the logic implicit in the aid effectiveness agenda that suggests that coordination between national and international partners at the country-level is the practical undertaking required to achieve the *means* - i.e. ownership, alignment, harmonisation, results and mutual accountability in the aid relationship - to the *end*: effective development aid. ‘Coordination’ therefore provides a useful catchall term with which to encompass both the tenets of the Paris Declaration and the intentionally slippery development terms ‘partnership’ and ‘participation’ upon which it is founded. While seemingly encompassing a lot, the logic of the coordination ideology is actually very simple, positing that when donors worked in isolation from their peers and in parallel to the developing state, official development assistance (ODA) was largely ineffective, thus the contrary may also be true.

This study seeks to unpack the reality behind the rhetoric of coordination measures carried out in the name of aid effectiveness in Uganda, using a purposive case study of the country’s health sector, and specifically the aid relationships that underpin the sector’s most high-profile multi-stakeholder forum: the Health Policy Advisory Committee.⁴⁸ The study posits initially whether meaningful coordination between heterogeneous partners at the country-level is currently even possible, before pondering whether, if not, there might still be something to gain from sustaining the framing that it is (i.e. that practice follows policy)? It is a research topic that, as I shall explain in the next section, was not the centrepiece of the original research design but which emerged – via the logic of induction – from the fieldwork experience.

⁴⁸ The Terms of Reference for the HPAC (see Appendix 5) state that: “HPAC is not a part of the Ministry of Health establishment and does not replace the regular decision-making process in the Ministry. HPAC is a parallel structure that facilitates and compliments the Government’s decision-making process. It provides a forum for health policy issues to be discussed and an opportunity for health sector stakeholders to gain consensus on contentious issues.”

The Value of an Iterative Research Design

An advantage of taken a mixed methods approach in the social sciences is that it permits an iterative approach to research design and the freedom to make alterations to the study topic according to the reality on the ground. Such freedom reflects with my epistemological stance of interpretive induction.

This is not to suggest however that I embarked on fieldwork a firm research idea. Instead, I had formulated a research topic and accompanying design that focused my gaze very firmly on Uganda's health sector and the impact of aid flows to it, but which nevertheless afforded me the freedom to cast my net far and wide within that confine. The original research design for the fieldwork thus articulated the research topic in the form of a broad question: in what ways does international development assistance mediate the relationship between state and non-state provision of key medical services in Uganda? The topic was elucidated upon via eight sub-questions, derived from an extensive literature review undertaken in 2006 and looking at the interplay between recent shifts in the development agenda which demanded increased and more effective aid, good governance and the fulfilment of social development targets such as the Millennium Development Goals (with their strong health focus).⁴⁹

The original research design was structured around the eight core elements of social research design outlined by Blaikie (2000), and proposed a multiple, embedded case

⁴⁹ The original sub-questions were as follows: 1) Does current development thinking play a concrete role in shaping health policy and provision in Uganda? 2) Does current thinking shape the international development policies of bilateral donors such as USAID and DFID? 3) What channels other than budget support are DFID and USAID individual donors utilising to disburse aid within the country? 4) What are the limits to Uganda in shaping its own governance agenda? What governance-related conditionalities, if any, are accompanying current aid disbursements? 5) How will international perceptions of Uganda's governance climate guide the future of its donor-recipient relationships? 6) How is the commitment of non-state actors in health sector to good governance assessed? Are issues of accountability being incorporated into the good governance agenda? 7) What are the limits of health provision in Uganda? How can they be broadened? 8) How are global interactions facilitating the transfer of health policies to Uganda? And what parties are influencing this transfer of policies? (Buse, Mays & Walt 2005: 138).

study design influenced by Yin (1994), which took development-based organisations as the unit of analysis. Within this methodological framework, the in depth interview was envisaged to play a central role. It was in this regards that I took comfort from Hakim - who finds that “A study that takes organisations (or parts of them) as the unit of analysis may still collect information through interviews with individuals...” (Hakim 2000: 160) - and Namenwirth *et al.* (1981), who maintain that organisational representatives are able to distinguish between their own views and those of the organisation, which can in fact differ significantly.

The goal during the planning stage was to target four organisations that, by virtue of their different *modi operandi* and positioning vis à vis the Ugandan government would offer points of contrast and comparison with which to discuss health aid. These were the bilateral donors, the United States Agency for International Development (USAID) and the UK’s Department for International Development (DFID); the UN’s Specialised Agency for Health, the World Health Organisation (WHO); and the humanitarian non-governmental organisation Médecins Sans Frontières (MSF). At the time of planning I had high hopes that in addition to discourse analysis and in depth interviews, I would also be able to gain sustained access to the case study organisations in order to assume the role of participant observer. With hindsight however, it is clear that the latter objective was short sighted, failing to take into account the strictures of high-profile development organisations operating in aid-recipient countries.

I will deal with the issue of access in more detail in the next section but suffice to say my research design demanded immediate alteration on entrance to the field - Uganda’s capital city Kampala. Whilst I had received a promising response from USAID prior to arriving in Uganda in March 2007, I had received no response whatsoever from my other target organisations and subsequently struggled to make contact once in situ. During the early months of fieldwork my research diary was littered with entries concerning ‘out of office replies’ and non-committal responses. Moreover, it became rapidly apparent that the one organisation which had sounded positive about my access request – USAID – was going to be the least equipped to

fulfil it. Yes, USAID could possibly allow me a few meetings with USAID staff - intense planning cycles and staff leave permitting - but I wasn't going to be allowed to spend sustained periods in USAID's high-security building as a participant observer.

The upshot of my early stumbles in the field was that I decided to cast my net further than the four case study organisations. To get ideas, I bought the newspapers every day and set about mapping out the organisational structure of Uganda's health sector, noting the diverse range of stakeholders involved and their specific interests in sector affairs. The newspapers in Uganda – specifically the *New Vision* and the *Daily Monitor* – are a surprisingly rich source of development and donor information. Indeed it would seem that if a donor or a non-governmental organisation (NGO) is undertaking something new in Uganda, they are keen for the Ugandan people to know about it – it is the logical extension of the donor preoccupation with attribution for results. Subsequently donor and NGO projects/project tenders made it in into the newspapers, as did announcements concerning major health incidents, new treatment protocols and of course health-related scandals (Global Health Initiatives, the Global Fund to Fight AIDS, TB and Malaria and the Global Alliance for Vaccines and Immunisation claim a surprising number of column inches). In addition, it became clear that the Ministry of Health was just as active a protagonist in the press as the donors, and consequently that there was a serious appetite for health news in the general populace. Finally, and rather helpfully for me, major events and conferences in the health sector were also announced and reported upon in the dailies. In short, newspapers helped to fill the information void that I faced at the start of fieldwork and enabled me to devise more robust strategies to overcome the problem of limited access, pointing me in the direction of new people to approach and up to date topics to approach them about.

In addition, in the early months in the field I attempted to capitalise on my dual nationality as British/Irish to make some approaches to the respective donor agencies. Much to my surprise, the health focal point at DFID in Uganda turned me down point blank, refusing to concede even to a single meeting and suggesting that

as he encountered so many similar requests for research access he couldn't possible agree to them all.⁵⁰ This early refusal from an organisation I thought to be a safe bet proved a huge knock to my confidence, and as the health team was a one-man show I couldn't foresee a way to circumvent the blockage (I had encountered the archetypal gatekeeper). Thankfully I had more luck at the Irish Agency for International Development, which despite having recently withdrawn from of the health sector as part of a division of labour exercise nevertheless agreed to a meeting, during which the ex-focal person for the sector provided me with valuable information about current developments and supplied me with several contacts for snowballing. Moreover, it was through this meeting that I first learnt about the existence of coordination fora in the sector and decided that I should look into requesting access. Ironically, it was the down to the fact that my request to attend the donor health forum, the Health Development Partners (HDPs) Group, was formally denied (on the basis that I was not a signatory to a Memorandum of Understanding) that I developed an interest in coordination groupings in the sector, their *raison d'être* and rules of engagement, and gaining access.⁵¹

The chance to attend a coordination forum in the health sector – one that wasn't governed by a Memorandum of Understanding - didn't actually materialise until eight months into fieldwork. And I was most gratified to be issued with a formal invitation from the Ministry of Health, which I had secured via a tip off from the WHO country office. I'm going to expand on how I finally gained permission to use WHO as a case study in the next section but for now I should impress that personal networks are incredibly important in Uganda. Poor Internet access (and a general failure to update organisational websites) coupled with the absence of a citywide phone book makes contact information very hard to come by in the public domain. Therefore I was relieved to find that the personal mobile phone numbers of

⁵⁰ Email from DFID's Health Representative in Uganda, dated 27th February 2007.

⁵¹ I was denied entry to the higher-level health sector fora via an email from the Chairman of the Health Development Partners dated 25th April 2007, into which all the HDPs were cc-ed. The explanation was as follows: "Participation in the monthly meetings... is limited to representatives from all organisations/agencies listed in the Memorandum of Understanding between the Ministry of Health and the Development Partners for the implementation of HSSP II [Health Sector Strategic Plan II]. Consequently it will not be possible for you to participate in these meetings." See Appendix 6 for a copy of the Memorandum of Understanding (MoU) in question.

colleagues and acquaintances could be supplied quite liberally following a successful face-to-face meeting, facilitating rapid snowballing within certain networks. Subsequently, it was the right name, dropped in the right ear that helped me win an invitation to the biennial National Health Assembly and the annual Joint Review Mission in October 2007. Together these conferences represented my first sustained opportunity to see the dynamics between Uganda's multiple health stakeholders play out at first hand.

The National Health Assembly (NHA) and the Joint Review Mission (JRM) – which were two days and three days long respectively in the same week – differ in that the former places the greatest emphasis on the district and community levels (i.e. the health providers) while the latter is more of a holistic sector overview (i.e. more policy driven). Together they represent major events in the sector calendar, as was demonstrated by the mass turn out for both.⁵² Attendance at the 2007 NHA fluctuated between around 300-600 people each day, and included a wide range of stakeholders including high-level Ministry of Health staff, MPs, donors, non-governmental figures and of course representatives from Uganda's 83 districts. The JRM was a smaller affair – 250 invitees – but again a wide range of stakeholders were in attendance from: the Ministries of Health, Finance and Public Service; Parliament; the Private Not-For-Profit sector; the trade unions; the prison health services; the media; and academia. Moreover, the turnout of the Health Development Partners at this forum was remarkable – I personally noted staff from: Belgian Technical Cooperation, DFID, Danish International Development Agency (Danida), Swedish International Development Cooperation Agency (SIDA), WHO, Japan International Cooperation Agency (JICA), the Italian Cooperation, the World Bank and USAID.

The JRM represented a unique chance for me to put names to faces and to ponder the dynamics amongst the heterogeneous partners. Naturally, I took copious notes on all

⁵² The need for and reasoning behind holding the annual JRM is stipulated in section 6.2.1 of the 2005 MoU, which reads "The Joint Review Mission (JRM) shall be held once a year. The mission will review the performance of the health sector during the previous financial year and agree on sector priorities and resource allocation for the next Financial Year. The JRM shall also monitor the implementation of the MoU." Again see Appendix 6.

manner of topics but the three things I would mention here are the behaviour of the donors, a disappointing day of group sessions and my general confusion as to the forum's actual purpose once it was all over. To elucidate briefly: I noted that although just about every Health Development Partner in the sector was represented at the JRM, it was only the HDP Chairman (from BTC) who would formally address the forum. The HDPs therefore would confer during the day before arriving at common positions for him to voice. This, it was later explained to me, helped create the semblance that the HDPs spoke with 'one voice', but at the time I found it most peculiar given how readily the other forum participants spoke up and over each other whenever the chance arose (taken together the forums were lively affairs, full of debate and laughter). At a subsequent health sector conference held in May 2008 – the Mid-Term Review (MTR) of *Health Sector Strategic Plan II* - I again noted unusual donor behaviour when on day one of a three-day conference, all the HDPs showed up only to say nothing at all. An HDP representative explained to me that because the MTR was more of a policy forum the Government had to own and lead the process, hence it was right that the donors take a back seat. Such behaviour confirmed my suspicions that the behaviour of the HDPs in joint coordination fora was at once strategic and premeditated. This led me to question both the value of the strategy and its implications vis à vis the coordination ideal; in short, if the engagement is staged, can it still be meaningful?

On day two of the three day JRM the participants split into working groups to discuss particular facets of the sector's remit and to devise 'undertakings' – or priorities - for the coming year. I chose to attend the breakout session that appeared to have the greatest relation to development aid: the Budget Framework Paper Working Group. After a promising start I had to mute my exasperation as the group failed to stay either on topic or to devise realistic targets. I noted that the two donor representatives in our group of 20 quickly lost all interest and sat back, typing on laptops, while certain special interest groups tried to usurp the session to get their issue prioritised. I found it a frustrating experience and was initially quite worried that terrible things would befall the health sector if the undertakings the group had adopted were ever prioritised. That was, until I was struck by the revelation that it didn't actually

matter; that the session, while obviously valuable from the perspective of giving certain people a rare opportunity to *participate* in sector discussions, was otherwise inconsequential. It was quite simply not an occasion for *decision making*. Hence the donors' palpable boredom and the entire group's lack of focus. Indeed, my suspicions as to the general futility of the exercise were confirmed on the final day of the JRM when the priorities to emerge from each working group were assembled to create a list of undertakings for the entire sector. It then became abundantly clear that (by and large) the same undertakings emerged from every annual meeting of the JRM, as the resources required to action them remained wanting. I was left wondering therefore, what had been the point of hundreds of people assembling at great expense to reach the same inevitable conclusions?⁵³ It was following the NHA and JRM therefore that my growing conviction that there was something worth investigating in the coordination ethos took hold.

Following the NHA and JRM I was faced with the decision of whether to retain my case study focus, which still hadn't really got off the ground, or to widen my study sample to try and gain insights from more disparate groups within the health sector. By this time I was au fait with the Health Policy Advisory Committee (HPAC) - the most important multi-stakeholder forum in the sector (meeting monthly) and one half of the Country Coordination Mechanism for the Global Fund to Fight AIDS, TB and Malaria - and had noted a number of the HPAC members at the NHA and JRM fora. In short, following the NHA and JRM I knew whom to approach and under what pretext (so many issues were discussed at these fora that I had gleaned what the key issues were for each stakeholder). Subsequently at the eight-month mark, I decided rather pragmatically to attempt to do both – to keep up my efforts with the case study

⁵³ It is an aside to the coordination debate to posit how much these combined conferences cost to put on, but given the venue – the upmarket Speke Resort on the shores of Lake Victoria – the food - a full lunch and two tea/snack breaks each day - and full board for all of the out of town visitors I can comfortably suggest a bill exceeding \$100,000, which it should be noted was paid for out of a Partnership Fund paid into by the donors (Partnership Funding is addressed in the empirical chapters of this thesis). Knowing this helps put into perspective how important such conferences may be for the morale of attendees, specifically the district representatives who are for the most part physically and intellectually removed from centre-level structures (i.e. where the decision are made). Viewed in this light, the opportunity for Uganda's health service implementers to socialise in an upmarket setting, to air grievances and/or publicise successes to an audience that boasts the higher echelons of the Ministry of Health is probably a very good argument in favour of participation.

organisations whilst concurrently trying to get interviews with as many representatives of the HPAC forum as possible.

That said toward the end of the fieldwork period in May 2008 I had informally put the case studies to one side and prioritised the HPAC's membership (specifically the members with a vested interest in ODA) as my basic study sample. This is demonstrated in how many really crucial interviews I amassed during the last two months of fieldwork, when the research topic really came together. That's not to say that I had completely discarded my case study options. Let us not forget I had fortuitously included three HPAC members in my original sample – two bilateral donors (with DFID superseded by DANIDA as a case study) and WHO. MSF therefore became the odd one out and fell to the wayside. Yet that in itself was helpful as regular access to the humanitarian non-governmental organisation had proved nigh impossible to sustain (MSF's staff spend the majority of their time out of Kampala in areas out of bounds to most researchers).

By the end of fieldwork, using my revised sample I had successfully secured interviews with just about every HPAC member group with a vested interest in development aid to the health sector: the Ministries of Health and Finance, the majority of the HDPs, the Chair of the AIDS Development Partners, and the lead representatives for civil society and the Not-For-Profit Sector. It followed that once I was more certain about my research topic it became easier to convince people to meet with me. In addition, through the process of snowballing, one door inevitably led to another and the experience confirmed that people were happier to meet someone who had already met with a colleague. Therefore while I will admit that the momentum took a while to build during fieldwork, I am happy that the thesis topic has been derived from the process of induction and not from a preconceived idea I may have had about what was important in Uganda before I arrived.

Together my interviews, conference material, field data and the additional material I had secured via my case studies served to provide a rich overview of the coordination architecture underpinning Uganda's health sector. Moreover, my

investigations had unearthed a rabbit warren of sub-group coordination networks operating beneath the HPAC. It was in these fora that I realised the seemingly homogenous partners were busily negotiating difference and comparative advantage, forming alliances and most importantly agreeing on common positions before facing their government partners at the HPAC. By the end of the fieldwork period therefore, the iterative nature of my original research design had been put to the test and proved its worth. On returning to the UK in June 2008 I was sure that my thesis would be focused on the multiple alliances I had witnessed in the field, and specifically on pondering the tangible properties of the coordination discourse I had witnessed put into practice.

Researching Development-Based Organisations: Barriers to Access

I want to say something specific about my experience of researching development-based organisations because it wasn't an issue I had seriously thought through when preparing my research design. Moreover, although I had taken guidance from the likes of Crewe and Harrison (1998) and Mosse (2005) before embarking on my fieldwork in Uganda, I had not fully internalised the distinction that they were on the 'inside' of the development world they researched, while I would remain resolutely on the 'outside'. I will elucidate further on my positioning in the research in a later section but for the purpose of this discussion it is enough to note that my outsider status initially had a detrimental impact on my access in the field.

The harsh truth is that while the pursuit of a PhD feels incredibly important to the student, it carries little weight in the wider world (of development at least). It offers you nothing to barter with, leaving you reliant on good will and good networking to operationalise your methodology. Moreover, the insignificance of the personal PhD endeavour is compounded if you consider the demands placed on the average development worker in the field in the form of: the annual planning and reporting calendar; field visits out of Kampala; work obligations abroad; months of annual

leave (to compensate for living away from home); two- to three-year postings (i.e. massive staff turnover); endless meetings to attend with partners, beneficiaries, and representatives from headquarters; obligations to entertain visiting missions and researchers; and all this on top of your actual work – which may be as a technical specialist, a team leader or a diplomat. To enter into this fray and ask for a meeting when you have nothing to offer of strategic value is a humbling experience.

Looking back, the issue or - to be more explicit – the *problem* of access dominated the entries in my research diary. In my case I can see now that there were at least three types of barrier to overcome which, in descending order of importance, I would term: the official, the logistical, and the physical. I'll use the four case studies that I included in my original research design - DFID, USAID, WHO and MSF – to exemplify the existence and effects of these barriers in the field.

To start with the 'official' barrier, I refer of course to gaining permission to carry out the research. Clearly in the DFID case therefore, I failed at the first hurdle: the focal person for health at DFID deployed his prerogative to say no. Furthermore, he used it on two occasions 14 months apart, despite my having greatly demoted my demands on his time (when I first approached DFID I had hoped to do a full case study, by the end of the fieldwork all I wanted was a single interview). My reflexive self could find lots of reasons to the effect that I had made a faux pas in my approach but sometimes you just have to allow that some people will say no. With regards to USAID, my experience couldn't have been more different: I received a positive reply from the US Head of Mission before leaving the UK. On arrival the Health Team Leader at USAID was primed to meet me, yet feely admitted that if the order hadn't come from above her head she would never have conceded to the research (she was brand new to the job and exceedingly busy). In short, with USAID I had picked the right gatekeeper first time. I should state however, that having met with the Health Team Leader, she couldn't have been more helpful and the enduring problems of access I experienced at USAID centred on the logistical. WHO was a different case entirely. I originally met with a key staff member who had been recommended to me via another contact. She explained I would have to get permission on two levels,

firstly from the WHO Representative in Uganda (WR) and secondly from the staff themselves. Subsequently, the process of navigating officialdom at WHO was lengthy: it took me two meetings, two drafts of my research proposal and an official letter from Edinburgh university to convince the WR; it took a third, longer draft of my proposal, and a presentation at a staff meeting to convince the staff. From first contact to first official interview at WHO took 7 months (not to mention countless emails and phone calls) but it was worth it, because once I had the official stamp of approval everybody I approached at WHO appeared willing to meet with me. Moreover, through my network at WHO I was permitted to attend monthly meetings of the UN Health Cluster, which the organisation heads. Turning now to MSF Swiss (I should specify that there are several MSF missions operating in Uganda and I had the most positive response from the Swiss division), although it took me a while to track down the Head of Mission, he was actually very forthcoming. However when we met, he explained that I would have to apply for official research permission from the MSF research office in Geneva (which tracks all the research carried out on the organisation). This process took several months and taught me that non-governmental organisations, which rely on voluntary donations, have to be more careful with their reputation than publicly funded ones.

As a final aside on officialdom, I should also note that I applied to Uganda's National Council for Science and Technology, which is a necessity for carrying out research in the country; rather than posing a barrier however, the US \$300 price tag and lengthy application are better depicted as boxes I had to tick during fieldwork.⁵⁴

Moving on now to the logistical barriers to fieldwork, I've already hinted at why it may be difficult to pin down the staff of development-based organisations, even if the permission and the will are already in place. It would be too laborious to recount all the numerous delays I encountered in the field (even following a tentative commitment from the interviewee) yet to provide a brief overview the main delays I encountered at USAID related to the intense annual planning cycles the staff endure and which necessitate lengthy delegations from HQ, annual leave and staff turnover.

⁵⁴ <http://www.uncst.go.ug> [Accessed 03/05/10].

At WHO, the central issues concerned staff having to work both up-country and out of the country on numerous occasions, and the mandate for the team to respond to real-time health emergencies, which in the course of 15-months in Uganda included outbreaks of Marburg fever, cholera, Hepatitis E and Ebola. Access to MSF Swiss was also hampered by staff turnover (the Head of Mission actually changed over during the early months of my fieldwork) and the fact that all of the staff are almost consistently out of Kampala, in areas strictly out of bounds to the researcher. With the best intentions imaginable, and concerted effort on both sides I had only managed three meetings with MSF Swiss in seven months - which was actually excellent considering how small the visiting staff pool of staff is to Kampala. Yet the prospects for new interviewees looked slim and the hope that I could amass enough material to produce an individual MSF case study soon faded.

To finish up with physical barriers to access, it's clear that several of the issues I've categorised as 'logistical' barriers could just as easily have been categorized as 'physical' (e.g. when staff are up-country or abroad). But what I am referring to under this banner is actually a more rudimentary form of physical barrier, and it is perhaps best exemplified using the USAID case study.

The USAID office in Uganda, situated as it is in a shared compound with the US Embassy and all other US government departments that operate in situ, is an imposing site and the first thing to be noticed besides the numerous guards at each entrance is that cars aren't allowed to pause next to it. Entrance is by appointment only and proposed visits must be recorded in advance in a logbook held at the first of two secure receptions. Here, if you are fortunate enough to have secured an appointment, you will have your passport checked; moreover, your person and your bags will be scanned, your digital media will be temporarily confiscated and your mobile phone will be switched off. After clearing the first reception it is a short walk outdoors to the bombproof USAID building, and a second secure reception. Here you will have your body and bags rescanned and your mobile phone removed. Then you wait for the person you are meeting to be called to reception and essentially take custody of you. On their arrival you will be asked to hand over your passport to a US

marine who will exchange it for a temporary pass to be worn in clear view at all times. Please note that possession of this pass doesn't imply that you are now free to wander within the confines of the USAID building, the person who has signed you in will remain responsible for you until you leave and will even have to accompany you to the bathroom should the need arise. It is helpful that USAID staff habitually warn their guests to allow an extra 30 minutes to clear security.⁵⁵

USAID is of course the extreme example of a hard-to-access development organisation in terms of physical impediments, but even government ministries and NGOs with offices in Kampala will operate some form of security. The walled compound and security guards are givens. After this the variables are whether or not the guards are armed, what ID you will be asked to show on arrival and whether or not you'll be asked to formally sign in. The idea, in short, that as an 'outsider' you could simply call in for an impromptu chat at a donor or UN agency is ludicrous. Development agencies operating in Uganda may be set up to help the people of the country, but the physical barriers erected around their staff would suggest that aid's beneficiaries are also in some respects 'outside' development.

The official, logistical and physical barriers I encountered with development-type organisations while operationalising my fieldwork brought home to me the wisdom of spending a sustained period in the field. I was in Uganda on and off over a period of 15 months (10.5 months in all), and while I might have got by with a little less time in the field, the barriers I encountered as an 'outsider' remained so arbitrary and opaque to me that I could have never foreseen where to make the cuts.

Reflexivity

While many of the issues demanding reflexivity have been addressed at earlier points in this chapter, there are several more that deserve attention here.

⁵⁵ Having since had the opportunity to visit the USAID compound in Rwanda and having heard accounts from other people visiting USAID in other countries, I understand that my experience of the high-security US compound in Uganda is standard fare post 9/11.

The Wider Relevance Of The Setting And Topic: The Grounds For Generalisation

As suggested, the case study of Uganda's health sector was arrived at through purposive sampling. The country's health sector is remarkable for its high dependency on development aid (over 50%), as well as its now mature commitments (in place since 2000) to the World Bank's Poverty Reduction Strategy process and the Sector Wide Approach. The upshot of these developments is that the GoU has opted for a formalised relationship with its health donors, as established in the country's 'Partnership Principles' and the MoU that exists between the GoU and its Health Development Partners. These features taken alone would have been sufficient justification for an in depth study of the aid dynamics underpinning Uganda's health sector, which has to date been lacking, but there is yet more that marks Uganda out for special attention. Viewed in the 1990s and early years of the new millennium as a 'donor darling', declining governance ratings and scandals involving the GFATM and GAVI mid-decade have combined to make Uganda the "Africa test" for development aid (Barkan 2005).⁵⁶

Whilst widespread generalisation has never been an objective of this study, it is clear that there are several issues running through the empirical chapters that may warrant comparison with other settings, for instance Uganda's overt commitment to the tenets of aid effectiveness and its renewed concerns over aid dependency in the face of Global Health Initiatives such as the GFATM. Nevertheless, the thesis forwards Mosse-inspired propositions (Mosse 2004; 2005) derived through the process of induction, as opposed to overt generalisations.

Limitations Of The Thesis Study

A PhD thesis study is by its very nature limited. It is worth stating nonetheless that the stipulation to focus on a single issue, combined with finite time, financial and

⁵⁶ Barkan actually stipulates that Uganda is the Africa test case for US foreign policy: "Uganda presents the Bush Administration with the 'Africa test' of its announced policy of promoting freedom and democracy around the world. If the Administration cannot pass the test here, where is the policy credible?" (Barkan 2005: 23) Yet with the centrality of the good governance agenda to international donor policy, the same question could be asked of aid generally. See Chapter Two for more detail on Uganda's waning governance ratings since the turn of the millennium.

human resources precluded me, like all researchers, from exploring every aspect of my subject matter, even to my own satisfaction. Moreover, as highlighted at some length within this chapter, my particular research topic and positioning as a development ‘outsider’ curtailed or - to frame it more positively – *informed* the breadth of my study yet further. Therefore while I am generally happy with the focus of my final study, I acknowledge that there were, and are, of course numerous related areas of study worthy of further exploration. I suggest just few of these in my thesis conclusion (Chapter Eight).

Methods

Although the majority of the research methods utilised for this study are qualitative, some quantitative methods were also used, for instance to gather data on patterns of donor giving.

From the qualitative toolbox, discourse analysis was a key research method employed at all stages. In this context I refer to a variety of source types: peer-reviewed and non peer-reviewed academic publications, the strategic plans and policy briefs of various donor/development organisations, the strategic plans and sector reviews of the Government of Uganda. I also consulted the OECD Development Assistance Committee Creditor Reporting System (for detailed information on aid flows) and a host of grey literature, including: evaluations and opinion pieces on overseas development aid, Uganda and the aid-funded interventions being undertaken in Uganda’s health sector, and the Ugandan and international press.⁵⁷

Discourse therefore awarded me a longitudinal view with which to chart the emergence of the modern aid effectiveness agenda. It was also very important in highlighting the disjuncture between donor plans and donor activities in the fieldwork country, evoking in this instance Mosse (2005). The disconnect between policy and practice rapidly came to make sense from my vantage point in the aid-recipient country, where five-year plans produced at donor headquarters were

⁵⁷ <http://www.oecd.org/dataoecd/20/29/31753872.htm> [Accessed 22/09/10]

naturally waylaid by the everyday realities of operating in Uganda. Moreover, by the pragmatic realisation that ‘man is not an island’ in the modern aid environment - put simply you have to get along with a host of heterogeneous stakeholders to get anything done. Plans, therefore, are often subject to manipulation or outright rejection on the ground even if they are sustained superficially.

Similar conclusions emerged from my investigations of national strategies and evaluations. As in many developing countries, in Uganda policy represents an ideal of what might be done, yet often exists without the impetus – i.e. the resources – for implementation. Nevertheless, the very existence of policy tells a story and it is insightful that some donors foresee policy as an area for their input (Riddell 2007). In a related vein, it is remarkable that many of the national reviews of the health sector conducted in Uganda are carried out using basket-style funding.⁵⁸ If we now allow that policy and statistical quantification serve as triggers for donor funds (Ferguson 1995, Escobar 2000) then the proliferation of donor-funded policy and review in Uganda’s health sector also belies the linear logic of practice following policy.

Another area where discourse analysis played a really integral role was in gaining a better understanding of the Global Fund to Fight AIDS, TB and Malaria (GFATM). It was incredibly helpful that despite the strange positioning of the Fund in country - whereby it is at once absent and omnipresent (the GFATM maintains no country presence yet regularly dominates the agenda of health sector fora) - the GFATM is universally praised for its commitment to public transparency (Oomman 2007). It fulfils this commitment via an extensive website, which provides all manner of supporting documentation including: policy documents, statistical information on grants, updates on current awards and numerous links to internal and external audits.⁵⁹ I drew on this resource at length.

Spending a sustained time in the field allowed for the absorption of a lot of contextual data. I have already mentioned the value I attached the local newspapers

⁵⁸ The term basket funding is explained in box 1 p23-24.

⁵⁹ <http://www.theglobalfund.org/en/> [Accessed 03/05/10].

but the role of participant observer was also very important, even if it wasn't feasible for me to gain sustained access to development organisations or high-level coordination fora. It helped that my social circle was built around actors in the health - if not development - sphere, who were for the most part connected to a healthcare provider I had once worked for in Kampala (please see the next section for expansion). These friendships forced me to question the significance of the coordination circles I was attempting to infiltrate in Kampala, which appeared totally disconnected from the everyday realities of providing healthcare. It was certainly telling that my healthcare friends were unable to provide me with any inroads into my sample grouping of high-level donor, government and civil society representatives.

The semi-structured interview was of vital importance to my fieldwork. I have already discussed the access difficulties I experienced during fieldwork at some length, the upshot of these was that when I did secure an interview I was without question grateful. In so far as my gratitude is expressed in this thesis, I hope it has impacted positively: via my endeavours to represent people fairly and truthfully, and in an express effort to quote people within the context of their comments. As to how my feelings of gratitude impacted on the fieldwork, I would admit to *over* preparing for interviews. This was at once a consequence of limited access and the realisation that the coordination networks I was attempting to infiltrate were extremely close knit. Indeed, a pressure I felt keenly throughout the fieldwork period was that I couldn't afford to have a bad interview. In my mind, the doors that were opening sequentially – through snowballing - could just as easily close sequentially. This was, in all probability, paranoia common to the lone researcher, but my response to it was to over prepare for interviews believing in most instances quite rightly that I would never get the chance to meet with this person on an individual basis again. I am without question a fan of the semi-structured interview and I would defend this stance, again citing the barriers of access - it simply wouldn't have been plausible for me to go in expecting to have an informal chat. Semi-structured interview transcripts provided me with the means to appear purposeful and serious, and the flexibility to allow people to veer off on their own tangents of interest. As to the interview guides

I employed, throughout I cast a broad net: asking about the respondent's job, the organisational *modus operandi*, working relationships with other partners and something current from the newsreel (ten questions at most). As time moved on, and my research topic became more refined I continued to ask similarly broad questions but demanded more clarification on the areas that really sparked mine - or the respondent's - interest. I certainly wasn't a slave to the interview guide however, as is demonstrated in the empirical data addressed in this thesis, the majority of which I couldn't have envisaged prior to the fieldwork. My over-preparation therefore, didn't stem from an attempt to control the conversation but to ensure that I could readily comprehend what was said to me, so as to get as much as possible out of every meeting.

By the end of fieldwork I had interviewed twenty seven representatives of the Health Development Partners (note that almost half of these respondents came from within WHO), four government officials (targeted for their association with health aid), and five civil society representatives. However that was in addition to numerous phone calls and emails, and more impromptu meetings at coordination fora etc. Therefore while the Health Development Partners are clearly over represented in the interview sample, this was offset to some extent by the over representation of the government partners at joint stakeholder fora and in national strategies, policy discourse etc. Indeed the top echelon of Ministry of Health staff are so in demand that coordination fora provide the only feasible way for the average researcher to see them in action. As the Chairman of the HDPs explained:

“We [the donors] are the culprits in a sense that we often invite these people to come and testimony of their experiences in Uganda...and they have to participate as representative of their country at this conference and blah, blah, blah...And at the Ministry what do you have? Three Ministers, a PS [Private Secretary] and a Director General. And one of them always has to be representing the country because you cannot have an assistant commissioner to represent Uganda in a high-level conference or forum. And the result is these people are often out of the country” (BTC Interview 10th April 2008).

Happily therefore, I was able to witness this elusive echelon of the Ministry on several occasions from the vantage point of participant observer.

In light of my multiple methods, by the time I came to analyse my data I was confident that I had gathered sufficient resources to verify the internal validity of the data using triangulation.

Ethics

Before entrance to the field I addressed the ESRC *Ethics Framework* and Edinburgh's School of Social and Political Studies *Research Ethics Policy and Procedures*; regarding the latter, it was concluded that I would be a 'level 1' candidate.⁶⁰ Therefore while I do not regard the final research topic as overly controversial, I have opted to obscure the identities of my respondents (although I do acknowledge what organisation they work for). This decision has been informed by the *Ethical Guidelines for Good Research Practice* issued by the Association of Social Anthropologists (1999) and my own understanding of the development community in Uganda.⁶¹ To clarify, the pool of stakeholders working in the higher echelons of the health sector in Kampala is so small that the study participants likely know each other. Knowing this, it is my own point of courtesy that specific names be omitted from the study, even if organisational identities may yet provide enough of a clue to the people in the know.

My Position Within The Research

With regards to my positioning in the research process, I take my lead from Kleinman, who suggests that researcher's observations are best understood as "positioned interpretations of positioned interpretations" (1995: 75). My duty as the researcher is therefore to be explicit about my own position – background, social commitment, conceptual orientation etc - in order to shed light on my encounters with members of my target community, who are themselves positioned. Kleinman

⁶⁰ Level 1 is defined as: "absence of reasonably foreseeable ethical risks" (SSPS 2006: 2).

⁶¹ The *Ethical Guidelines* recommend that "As far as is possible researchers should anticipate potential threats to confidentiality and anonymity. They should consider whether it is necessary to even a matter of propriety to record certain information at all; should take appropriate measures relating to the storage and security of records during and after fieldwork; and should use where appropriate such means as the removal of identifiers, the use of pseudonyms and other technical solutions to the problems of privacy in field records and in oral and written forms of data dissemination (whether or not this is enjoined by law or administrative regulation)" (Association of Social Anthropologists 1999: 4).

stipulates that “The empirical results of this utterly human – though professionally disciplined engagement is positioned knowledge; that is a view from somewhere” (Kleinman 1995: 76).⁶²

While Mosse has depicted himself as a “Foucauldian subject within, as well as outside the discourse,” (Mosse 2005: xi) and Crewe and Harrison have acknowledged “We are clearly part of what we write about” (Crewe and Harrison 1998: 21), it should be clear by this point that my particular vantage point was different. For the majority of the fieldwork I was apart from the action – gaining insight to it only through the accounts of the protagonists, via the interview process. That said there were occasions where my peripheral placement permitted me first hand access to the action in real time, e.g. at large conferences and joint fora. Yet even there I may have missed some of the subtleties involved in the various group dynamics had I not also had the opportunity to question group members about their actions (utilising my outsider status). Drawing on a distinction outlined by Brewer (2000: 60) therefore I would say that on the few occasions when I was invited to really participate, I was inhabiting the role of ‘participant observer’ (adopting a new role) rather than ‘observant participant’ (utilising an existing one).

This said my outsider status during the PhD fieldwork should not obscure the fact that I had some prior experience of working and carrying out research in Uganda. During 2002-3, I spent six months working as an assistant to the manager of a private hospital in Kampala. Whilst in 2005, I carried out a month’s fieldwork looking at the country’s emerging private health insurance market. While neither of these experiences proved advantageous from the point of view of accessing development-based organisations in 2007-8, they did lay the foundations for a considerable degree of contextual and cultural familiarity with the case study country and a valuable social network in Kampala.

Crewe and Harrison acknowledge the impact of their social identities on how they have approached their fieldwork: “Our own social positioning, as white, middle-class

⁶² As opposed to a transpositional: “view from nowhere” (Nagel 1986).

anthropologists, has plainly inclined both of us towards a particular shared intellectual disposition” (Crewe and Harrison 1998: 21; also see Visser 2000). While I would acquiesce to inhabiting a very similar social position and intellectual leaning – in my case I am a white, middle-class social scientist – I find it more pressing to consider the impact of my positioning from the vantage point of my respondents. Here I think it is informative to address the different facets of my culminative identity in turn.

If I were to hypothesis which aspects of my identity were deemed the most important from the perspective of the Ugandan respondents I would say unequivocally my status as Caucasian and/or British/Irish. In the local dialects the word ‘mzungu’ is a universal catchall term for both these identities (translating literally as ‘foreigner’), and it was common for me to hear Ugandan respondents refer to me as such whenever speaking to their colleagues. Mzungu is a difficult term to fully unpack in the sense that it is rarely used in a derogatory fashion (at least in a professional setting) yet it remains a term that people at work - switching seamlessly between English and their local dialect - probably wish you hadn’t understood as referring to you. In such settings, the term is intended simply as a statement of fact. Nevertheless it is undoubtedly packed with certain assumptions about the bearer: that you are wealthy, enjoy some power/status and are an outsider. My experience of Uganda over the years has taught me that even if I were to live the rest of my life there, my first and most important identity would always be mzungu. Indeed the implications of the mzungu tag transcend native Ugandan society. At some level all expatriates in the field will infer similar assumptions about you based on your shared ‘foreignness’, and I have no doubt that at times I enjoyed preferential treatment. For instance, having asked an expat donor representative who would be the best person to approach for an official invite to a health sector conference the respondent suggested that I could simply gatecrash, inferring that my status as a white Brit would make it hard for a Ugandan official to turn me away; and while on the one hand I was distinctly uncomfortable with this suggestion I understood that it contained some kernel of truth, even if I wasn’t willing to put it to the test.

Regarding my nationality I have already admitted that I was guilty of shifting between my British and Irish identities depending on the audience. While the distinction would not necessarily make much of a difference to everyday Ugandans, I did perceive a slight bias in certain circles toward the Irish identity. For instance, Irish citizens do not require a visa to enter Uganda – they do not suffer from the baggage of colonialism. Similarly, within donor circles Irish Aid is well respected and considered “sincere” in government circles (MoH Interview 7th April 2008). Yet as I said, the difference is negligible, although it did make sense to alternate my nationality when it was to my obvious my advantage, i.e. prioritising ‘Irish-ness’ when approaching the Irish Agency for International Development and ‘British-ness’ when approaching DFID.

My status as a female researcher undoubtedly impacted on my research but in what specific ways I couldn’t confidently say (I have no basis for comparison). This was a more subtle aspect of my identity therefore. Indeed it is noteworthy that women are fairly well represented in the higher echelons of the Ugandan administration so the sight of a woman in a professional setting is not unusual. Moreover, in development circles women are probably slightly over-represented. Therefore I would suggest that it was really the amalgamation of the many facets of my identity - white, British/Irish, female, in my late twenties (at the time of fieldwork) and a student – that marked me out as a non-threatening prospect for engagement during fieldwork. This status no doubt helped and hindered my research in equal measure, as the picture to emerge was that I wasn’t very important so there was no pressure on respondents to meet with me, nor was I a cause for concern, thus they felt no impetus to avoid me.

Conclusion

My experience of attempting to access the coordination architecture underpinning Uganda’s health sector revealed how the broad rules and processes of engagement serve to police who is and who is not permitted to join the “negotiation process

proper” (Jeppsson 2002: 2059). For that reason it was clearly significant that a (non-legally binding) Memorandum of Understanding was used to exclude me from attending the Health Development Partners group, while I received formal invitations to attend joint coordination fora, the National Health Assembly, the Joint Review Mission and the Mid-Term Review. The former is an arena where the HDPs iron out their differences before coming face-to-face with their government counterparts at the Health Policy Advisory Committee, thus it’s imperative to keep those differences concealed. The latter are master classes in public grandstanding and diplomacy, where carried-over priorities attest that the real nuts and bolts of partnership are happening elsewhere, out of public view. To draw a parallel between my own experiences and those of Uganda’s health stakeholders therefore, it is clear that “access” is not a blanket commodity in Uganda’s health sector, and that no one party enjoys the keys to the kingdom. Rather, access to the processes of partnership in Uganda is multi-faceted and subject to negotiation, confirming once and for all that coordination isn’t an apolitical activity aimed solely at improving the effectiveness of aid. At stake are resources, power and reputation, hence why not everyone can be allowed to participate on equal terms. Subsequently, the tacit achievement of the coordination drive in Uganda is the superficial illusion that all parties are working together toward a common agenda. Such artifice evokes Mosse, who suggests that the ethnographic task is to reveal how, despite the fragmentation of stakeholder interests, development actors are constantly engaged in creating unity through political acts of composition (Mosse 2005 citing Latour 2000).

CHAPTER FOUR:

COORDINATION TO VISIBLY PURSUE THE MOST READILY PICK AND MIX ELEMENT OF THE NEW AID AGENDA

Introduction

In this chapter, I forward the proposition that ‘coordination’ is a slippery development term, which partners can pursue on a partial basis without having to entirely reject the ethos. In doing so I argue that even a partial adherence to the coordination ideology confers discrete advantages on partners, making the illusion of meaningful partnership engagement worth upholding. It is this ‘pick and mix’ quality therefore that has rendered coordination one of the easiest elements of the aid effectiveness agenda for partners to be seen to pursue.

‘Coordination’ in itself is not one of the trademark commitments of the *Paris Declaration on Aid Effectiveness* (Paris High-Level Forum 2005) in the same way as ‘harmonisation’ or ‘alignment’ are. Instead it is depicted as one of the central means to those ends: a universally agreeable tool, which appears to contain within it the logic for improving the effectiveness of development assistance by virtue of its rather simplistic appeal. This suggests that when donors and partner countries worked in isolation official development assistance (ODA) was generally ineffective, thus the converse may also be true. The failure to identify if the former statement denotes causation or correlation is a reflection of the inadequate evidence base currently underpinning debates over what works and what doesn’t in aid effectiveness (Riddell 2007). Moreover, it serves to explain this somewhat underwhelming finding of the *Evaluation of the Implementation of the Paris Declaration in Uganda*: “There is a general consensus in Uganda that theoretically the link between the Paris Declaration principles and aid effectiveness is plausible” (Office of the Prime Minister 2008: 19).

Furthermore, in the same vein as ‘capacity building’ (another means to an end), the term ‘coordination’ benefits from having no obvious downsides: a donor can’t be accused of throwing their weight around by offering to coordinate or capacity build in an aid-recipient country. An ostensibly innocuous term therefore, in this chapter it will be argued that when compared to the more problematic components of the new aid agenda – such as ‘mutual accountability’ - coordination has become one of the easiest aid effectiveness tools for stakeholders in Uganda’s health sector to visibly pursue. Conversely however, it will also seek to demonstrate that it is, nevertheless, one of the hardest elements to satisfy.

These ideas will be explored firstly through an examination of the formal partnership commitments that already exist between the government of Uganda and the Health Development Partners in Uganda (I will also explore partners compliance to them); and secondly, by exposing the innate differences that exist amongst even a superficially homogenous grouping like the donor contingent of the Health Development Partners Group. Such differences it will be argued, serve to make meaningful engagement incredibly difficult even within this group. Nevertheless the group has found ways of glossing over their differences to reap certain rewards, demonstrating that there may be advantages to maintaining a guise of homogeneity when it comes to facing up to your obviously heterogeneous counterparts in government.

As such, coordination’s undisclosed property in this chapter is derived from its pick and mix utility, which allows Uganda’s health partners to take or leave certain aspects of the coordination ethos without seeming to abandon it completely. Riddell laid the foundations for this line of argument when he suggested that “donors have adopted what could be described – quite accurately – as a ‘pick and mix’ approach to aid, morality and the obligation to provide it (Riddell 2007: 146). In short, just as the impetus for donors to provide aid remains voluntary so does the compulsion to reform aid practices, resulting in partners’ pick and mix compliance to aid effectiveness agreements. The crux of this argument is quite simple, donors and governments are actively precluded from coordinating in a meaningful way. Or to

draw on an age-old analogy, differences in funding restrictions, development objectives, *modi operandi*, and issues of sovereignty render Uganda's Health Development Partners the equivalent of square pegs trying – in some cases quite genuinely – to squeeze through round holes. That said, there is nonetheless enough advantage to be garnered from pursuing coordination objectives in a superficial manner, and this explains the partners' enduring faithfulness to the concept.

Before proceeding to the numerous obstacles that can undermine partner commitments to coordinate in Uganda's health sector, it is first important to underline how such commitments have been formalised and outline how successfully they have been implemented up to the present period. The aim in doing so is to illustrate the discrepancy between the rhetoric and the reality of commitments towards coordinated action in the sector.

Formalising Partnership Commitments in Uganda

While the Paris Declaration is now depicted as a watershed in the history of international development commitments, it is interesting that from the vantage point of the Ugandan government, it is merely a reworking of a set of principles it had developed four years earlier. Uganda's 'Partnership Principles' (see box 5 on p96) were published in 2001, in Volume 3 of the revised *Poverty Eradication Action Plan (PEAP): Building Partnerships to Implement the PEAP* (MoFPED 2001). Viewed as a part of this broader document, the 'Partnership Principles' can be understood as both a request by, and a mechanism for, the Government of Uganda to establish ownership of the new partnerships being stimulated by increased aid flows to the country.

The impetus behind seeking to stimulate more coordinated action on the part of the Government of Uganda (GoU) in 2001 was derived from its desire to receive a greater proportion of aid as general budget support, or more specifically, unconditional budget support. As such, the *Building Partnerships* document suggests

new ways of working which serve to reassure Uganda's traditionally risk averse donor community that Uganda can be trusted with aid delivered in this format. To proffer some key examples, it is proposed that, "all donors who are providing fully flexible budget support...should be invited to participate in the review of any sectors where they can contribute useful expertise." Moreover, that development partners raise issues of concern "in budget consultations, rather than imposing additional conditions on budget support" (MoFPED 2001: 72). The 2001 document even demands new forums to facilitate the new working relationship, in order to "exchange ideas on how the partnership is being implemented" (MoFPED 2001: 83), with explicit recommendations including: a more regular channel of communication for donors, and for government capacity to be strengthened across the board "so it speaks with one voice" in coordination forums (MoFPED 2001: 3). Joint discussion therefore, signals a component of the new aid agenda - as determined by the GoU - in 2001, and one which laid the basis for the institutional arrangements I found guiding aid relations in 2007-8. Furthermore, to encourage the more meaningful participation of donors in country-level deliberations, the 'Partnership Principles' asks the Health Development Partners to "increase [the] level of delegation to country offices" (MoFPED 2001: 4). This is an issue I shall return to in due course.

Additional to this notion of joint working in Uganda is an overriding appeal for Development Partners to respect the national government's ownership of central processes. Consequently, while donors are advised that they will be invited to participate in open discussion with the GoU, they are nevertheless warned that, "Government, on its side, cannot guarantee to agree with donors' positions, but will certainly take them into account in determining overall allocation" (MoFPED 2001: 72). This position provides an interesting caveat to the concept of coordination, which again appears to present different utilities to different partners. Therefore while I shall tackle coordination from the vantage point of the health donors later in this chapter, what can be discerned from this early government statement was that the GoU had initially hoped that coordination measures might provide some means of pacifying its donors by increasing their participation in the discussion processes that contribute to decision making. That it has since seen this ideal somewhat

backfire – as highlighted in the Chapter Two and again toward the end of this chapter (with budget support depicted as a “stick”) – again points to the lack of empirical grounding of the new aid agenda which fails to take into account the unexpected consequences of new aid initiatives (Walt *et al.* 1999b).

Box 5: The Poverty Eradication Action Plan (PEAP) Partnership Principles

The need for improved partnerships has been increasingly recognised both by the Government and by its development partners. At the 1999 Stockholm conference on 'Making Partnerships Work', a set of principles for the management of donor assistance was proposed by the Government delegation. These principles are as follows:

Shared commitment

Donor support will only be sought/provided for programmes that are in the Poverty Eradication Action Plan

In addition Government will ...

1. Continue with increased focus on poverty eradication [at minimum PAF funded programmes as a share of total budget will remain constant]
2. Continue with increased tax revenue effort
3. Assume full leadership in donor co-ordination process (at central, sectoral and district level)
4. Decline any offers of stand-alone donor projects
5. Strengthen monitoring and accountability (including value for money evaluations)
6. Continue to improve transparency and combat corruption
7. Continue to strengthen district capacity
8. Develop comprehensive, costed and prioritised sector wide programmes eventually covering the whole Budget
9. Further develop participation and co-ordination of all stakeholders (including Parliamentarians)
10. Strengthen capacity to coordinate across Government (so it speaks with one voice)

In addition donors will ...

1. Jointly undertake all analytical work, appraisals and reviews
2. Jointly set output/outcome indicators
3. Develop uniform disbursement rules
4. Develop uniform and stronger accountability rules
5. Ensure all support is fully integrated into sector wide programmes and is fully consistent with each sector programme's priorities
6. Continue to increase level of untied sector budget support
7. Increase level of delegation to country offices
8. Abolish topping up of individual project staff salaries
9. End individual, parallel country programmes and stand-alone projects
10. Progressively reduce tying of procurement

Source: MoFPED 2001: 3-4

Remarkably, *Building Partnerships to Implement the PEAP* most clearly pre-empted the Paris Declaration when it suggested that “The best way to harmonise donor procedures is to harmonise around the Government’s own procedures” (MoFPED 2001: 78). Considering that coordination measures – such as the fora and networks mentioned above - are just one means to achieving this end, it is interesting to note the other practical measures the GoU envisaged for itself and its partners to advance progress towards this vision. Thus donors were asked to “ensure all support is fully integrated into sector wide programmes and is fully consistent with each sector programme’s priorities;” to “end individual, parallel country programmes and stand-alone projects;” and to “progressively reduce tying of procurement” (MoFPED 2001: 4). In addition, the GoU appealed for the donors to harmonise with one another, imploring them to “jointly undertake all analytical work;” to “jointly set output/outcome indicators;” and to develop “uniform” disbursement and accountability rules (MoFPED 2001: 4).

On its behalf, the GoU hoped to facilitate the stipulated donor changes by: assuming full leadership in donor coordination (at central, sectoral and district level), by declining “any stand-alone donor projects,” by strengthening monitoring and accountability, and by developing “comprehensive, costed and prioritised sector wide programmes...” (MoFPED 2001: 3). Finally, although strongly favouring budget support in 2001, the GoU remained realistic that it might take some time for donors to move toward that aid modality. Consequently, it offered up progressively ambitious funding options to safeguard donor money in the short-term. The most simple of these was a vigorous project screening process, which still permitted donors to fund projects in the health sector so long as they met certain criteria, for instance to ensure compliance with sectoral strategies. The most important interim concession however, was the Poverty Action Fund (PAF) - a ring-fenced fund, which ensures aid intended for pro-poor areas is protected from mid-year budgetary cuts. Through this mechanism donors are permitted to notionally earmark budget support.

While the 2001 ‘Partnership Principles’ are an important footnote in the narrative of development cooperation in Uganda, clearly it is one thing to propose change and another thing to solicit commitment to it. Therefore it is remarkable that in 2003 the Government and the Development Partners in Uganda signed off on the *PEAP* and ‘Partnership Principles’, formalising their commitment to more coordinated and harmonised action at the country level. It was two years after this that the Paris Declaration on Aid Effectiveness was signed off at the international level, and although thought to add very little to the existing commitments in Uganda – one Ministry of Finance interviewee suggested “the Paris Declaration photocopied the ‘Partnership Principles’” (MoFPED Interview 22nd May 2008) – Paris has since been depicted as catalysing activities towards the fulfilment of both (Office of the Prime Minister 2008). One literal manifestation of this is believed to be the Development Partners mainstreaming of the ‘Partnership Principles’ (PPs) and Paris Declaration (PD) commitments into the *Uganda Joint Assistance Strategy* (Office of the Prime Minister 2008: 41).

The *Uganda Joint Assistance Strategy* (UJAS Partners 2005) is salient to this discussion by virtue of donors’ reaffirmed commitment to the international aid effectiveness agenda.⁶³ The document stresses that:

“The UJAS Partners understand ‘working better together’ to mean increasingly using common arrangements to deliver aid and to achieve a more effective division of labour among themselves in supporting specific sectors or programs. To this end, partners will strive to increasingly harmonize programming and policy dialogue, and to rationalize engagement in sectors, choice of aid instruments, and advisory capacity” (UJAS Partners 2005: 14).

It is also important for providing an early insight into the sort of challenges Uganda’s Development Partners were confronted with when attempting to develop their first joint strategy. Thus while the partners were united by a mutual recognition of the imperative to harmonise, they nevertheless struggled with the logistics of carrying

⁶³ The UJAS initially involved 8 donor partners but other partners have since joined, bringing the current coalition total to 12. The present grouping includes: African Development Bank, Austria, Belgium, Denmark, European Commission, Germany, Ireland, the Netherlands, Norway, Sweden, UK and the World Bank Group.

out a division of labour exercise.⁶⁴ Subsequently, questions arose over how comparative advantage should be assessed and indeed how this might change over time, and over the need for country office staff to regularly consult with, and to reflect the requirements of their different headquarters. Finally the completion of the UJAS strategy was said to have been delayed because “Different assessments of the risks posed by corruption and the political transition created tensions among some UJAS partners, making it difficult to draft a strategy acceptable to all” (UJAS Partners 2005: viii). Indeed, this idea of differing perceptions of corruption – as reflected in the different governance indicators donors utilise and the resultant risk minimisation strategies that they employ - is an issue I shall return to again in this chapter.⁶⁵ I suggest that this is perhaps the main barrier to meaningful coordination in the Ugandan setting.

In a further effort to formalise agreement over the proliferating aid effectiveness commitments emerging post-2000, the Ugandan Government and in this instance the Health Development Partners, signed off on a revised Memorandum of Understanding (MoU) in 2005.⁶⁶ That document, while neither mirroring the PPs or the PD, served to institutionalise their shared ethos in the context of the health sector and provided explicit instructions for managing the partnership. So for example, all parties committed to funding only activities reflected in the framework of the *Health Sector Strategic Plan II* (HSSP II), and to sit together at the Health Policy Advisory

⁶⁴ See box 1, p23-24 for an explanation of a division of labour exercise.

⁶⁵ The issue of measuring governance is contentious and even the forerunner of the ‘good governance’ agenda, the World Bank has remarked “The consensus among researchers is that, by and large, the broad governance indicators we have are what we will have to work with – no break through capable of providing an overarching, yet precise measure of governance is on the horizon” (World Bank 2006: 136). Moreover that “our knowledge of how to get ‘from here to there’ is less developed than our understanding of what well-functioning checks and balances should look like” (World Bank 2006: 172). Indeed, the complexity of the task is exemplified in the World Bank’s framework for monitoring governance, which in 2006 used a subset of 14 measures made up from: 5 out of the 14 World Bank’s Country Policy and Institutional Assessments, 3 of the Kaufmann-Kray aggregate indicators, and 3 selected indicators from the Doing Business database and the Investment Climate Surveys - amongst others (World Bank 2006: 128). The problem of quantifying governance is convoluted further when donors devise their own mix of indicators.

⁶⁶ See Appendix 6 for a copy of the 2005 Memorandum of Understanding between the GoU and the HDPs. Note: the 2005 MoU was a revision of an earlier 2000 version signed to agree coordinated action toward the first *Health Sector Strategic Plan*, as part of the broader Sector-Wide Approach. Moreover, it is now understood that the MoU will be revised again following the recent adoption of the Long-Term Institutional Arrangement in Uganda, which have seen additional partners – from civil society and the private sector – being offered representation at the Health Policy Advisory Committee (see Chapter Seven for more detail on this development).

Committee to advise on the implementation of it. Donors were awarded a larger joint role in the monitoring of the sector, while also agreeing to rationalise their use of technical assistance, to use national procurement systems (where possible) and to “work towards ensuring that budget releases are made according to a schedule agreed with the Government” (MoU 2005: 6.4.4). The GoU for its part, agreed to “provide overall leadership in planning, administration, implementation and monitoring of *Health Sector Strategic Plan II*” (MoU 2005: 3.1) and to ensure that the proportion of the Government budgetary allocation to the health sector would increase annually in real terms.

To sum up, the 2005 MoU between the GoU and the Health Development Partners (HDPs) provided a detailed framework for operationalising aid effectiveness rhetoric in Uganda’s health sector, and as such, a means of measuring adherence to an agreed set of standards. Thus it is in light of these commitments and the tenets of the Paris Declaration that one can now begin to assess the manner in which Uganda’s stakeholders have honoured their pledges to date. While three years (please note my fieldwork concluded in 2008) is not a sufficient time period to reach any definitive conclusions about the nature of partnership commitments in Uganda’s health sector, it is at least long enough to identify some of the main barriers to the ideal and to suggest why – during the second half of this chapter - meaningful coordination may be suffering in the short-term as a consequence of deeply-entrenched institutional cultures.

Operationalising the Health Partnership in Uganda

During the course of the fieldwork various interview subjects voiced strong opinions over where the GoU-HDP partnership had so far gone awry. This information was supplied on an ad hoc basis as opposed to systematically.⁶⁷ Nevertheless, even the

⁶⁷ The issue of compliance to the ‘Partnership Principles’ and the MoU was raised in interviews, on day one of the 2007 Joint-Review Mission, 24th October 2007 and on day three of the Mid-Term Review of HSSP II, 29th May 2008. The *Mid-Term Review Report* also stated that “Compliance with

opinions of these subjective commentators demonstrated enough consistency to induce some confidence in the main issues that have arisen to date when attempting to operationalise the health partnership in Uganda. Moreover, one output of a recent mid-term review of the Paris Declaration was a detailed country case study on how the Paris Principles have been implemented in Uganda during its first phase (Office of the Prime Minister 2008).⁶⁸ This has proved a valuable addition to the fieldwork material, both as a source of triangulation and as a source of additional interviewee input. I draw on these resources, in addition to salient MoFPED financial reports, throughout this chapter.

The first and most forthright source for evaluating compliance to the ‘Partnership Principles’ came in the form of a senior staff member at Uganda’s Ministry of Health (MoH Interview 7th April 2008) - a staff member who it should be remarked has been employed, at least in part, to clean up the image of the MoH following the Global Fund mismanagement. In a frank interview, he identified which of the ‘Partnership Principles’ government and donors had showed weakest adherence to so far. For government, they were: “Continue with increased tax revenue effort,” “Decline any offers of stand-alone projects,” and “Continue to improve transparency and combat corruption.” For the Health Development Partners, they were: “Develop uniform disbursement rules,” “Ensure all support is fully integrated into sector wide programmes and is fully consistent with each sector programme’s priorities,” “Abolish topping up of individual project staff salaries,” and “End individual, parallel country programmes and stand-alone projects” (MoFPED 2001: 3-4). When asked what problems there might have been in meeting these principles, the interviewee suggested weak discipline – for instance, the government is supposed to say “no” to stand-alone projects but hasn’t done so consistently – and a continued lack of confidence in government and government structures, which had seen some donors continue to favour parallel management arrangements. When then asked what repercussions there were for partners who failed to adhere to the PPs, the interviewee

the provisions of the HSSP II MoU has been variable on the part of the GoU as much as with the HDPs” (MoH 2008: xxii).

⁶⁸ The Accra High-Level Forum on Aid Effectiveness took place from the 2-4 September 2008. Unfortunately the country case study produced to evaluate the implementation of Paris in Uganda does not provide separate information on how stakeholders have behaved in each sector.

suggested that beyond waste and duplication there really weren't any. This highlights a central problem to the coordination ethos, and one seen echoed in the *Evaluation of the Implementation of the Paris Declaration* (Office of the Prime Minister 2008): a lack of mutual accountability.

The *Evaluation of the Implementation of the Paris Declaration in Uganda* finds a "general paucity of information on mutual accountability" (Office of the Prime Minister 2008: 61), and this is despite identifying several potential mechanisms deemed adequate for jointly reviewing progress toward accountability commitments. It also noted that whilst *UJAS* was explicit on how it intends to monitor progress toward the Paris goals of alignment and harmonisation, it remained less so on mutual accountability. Finally, while the report notes that there is a least one forum that the donors can draw upon to hold the GoU to account, there is as yet no forum that both parties can utilise for mutual review. Therefore, given that the commitment to mutual accountability is perhaps the most radical of the five proffered by Paris, it is a poor reflection of overall commitment to the Declaration that Uganda's government and donors have already been found guilty of attaching different levels of importance to each.⁶⁹ Moreover, even if the concept of mutual accountability is overlooked as simply a feature of an international initiative, the issue that the Ministry of Health interviewee highlighted was that if both sides of a partnership fail to meet shared commitments – whether completely or just inconsistently - then the high moral ground to demand compliance on either side is lost. To turn now to the HDP vantage point, to identify where donors perceive the two sides have been failing, one can begin to see how difficult it is to demand reform in a dysfunctional working arrangement.

The Chairman of the HDPs identified the following failings on either side of the health sector partnership.⁷⁰ For government, he identified a failure to increase the proportion of overall government allocation to the sector, and to consistently meet its

⁶⁹ The five tenets of the *Paris Declaration on Aid Effectiveness* are: ownership, alignment, harmonisation, managing for results and mutual accountability (High-Level Forum 2005).

⁷⁰ Please note that the appointment of a Chair for the Health Development Partners group is set out in the group's Terms of Reference. See Appendix 4.

reporting obligations to donors. For donors, he suggested a failure to rationalise technical assistance to the MoH, to submit new projects to the proper screening process, and to announce new funding to the sector as several areas where donors were undermining the MoU (BTC Interview 10th April 2008).

Additional data to back up these claims can be found in the *Annual Health Sector Performance Report FY 2006/2007*. The report notes that the percentage of the GoU budget being allocated to the health sector had actually decreased when compared with the previous financial year - slipping from 9.7% in 2004/2005 to 9.6% in 2006/07 (MoH 2007a: 83). It also found that non-*HSSP II* inputs such as technical assistance and project management costs continued “to take a high percentage of donor project funding at 31%” (MoH 2007a: 88); and that a significant proportion of donor project funding remained off-budget. Furthermore, that even excluding those funds, just 41% of donor project expenditure was reflected in the Mid-Term Expenditure Framework. Finally, the report noted that 74% of donor project expenditures were being made in the private sector, where the MoH was unable to ascertain the expenditure’s contribution to the realisation of sector objectives (MoH 2007a: 87). In sum, on the HDPs’ side, the report revealed that a significant proportion of project aid to Uganda’s health sector remained unaligned with sector priorities.

A further issue thought to be complicating the discussion over compliance to partnership commitments in Uganda - raised by the HDP Chair and likely to have skewed some of the statistics highlighted above - relates to the huge injection of aid now entering Uganda’s health sector as a result of Global Funding Initiatives like the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI). To provide a concrete example, a Public Expenditure Review in health identified that a trend beginning in 2004/05 - for overall donor project funding to increase while GoU financing decreases - directly coincided with the introduction of Global Health Initiatives to the country.⁷¹ And as

⁷¹ A summary of the Public Expenditure Review was presented at the Joint Review Mission of the Health Sector in Kampala on 24th October 2007 by Under Secretary at the Ministry of Health, Pius

the HDP interviewee points out, such funds aren't yet signatories to the 2005 MoU (although the GFATM and GAVI have now expressed an interest in joining (BTC Interview 10th April 2008)).

New developments in the international architecture of aid will no doubt pose new challenges to Uganda's existing health partnership (in other chapters I will deal more explicitly with Uganda's Long-Term Institutional Arrangements which are already signalling transformation for Uganda's aid management structures). Indeed, Uganda is already witnessing vastly increased funding to civil society organisations from the likes of GFATM and the President's Emergency Plan For AIDS Relief (PEPFAR), the impact of which is yet to be discerned.⁷² Yet Uganda's partnership arrangement could change again if the sector were to attract one of the new bilateral aid donors such as China, whose reputation suggests a desire to further economic as opposed to development concerns and a negligible interest in the Paris Declaration (Office of the Prime Minister 2008). Or should the new US Presidency choose to revise the vertical aid initiatives commenced under the Bush administration: PEPFAR and the President's Malaria Initiative (PMI). In short, while the new aid architecture will continue to alter the nature of coordination and partnership in Uganda's health sector, it's difficult to speculate on what form these changes might take at this time.

For the remainder of this chapter therefore, I shall focus the discussion on why the early years of partnership in Uganda's health sector might not have yielded stronger adherence and compliance to the commitments voluntarily entered into by the GoU and HDPs. Specifically, I will concentrate on the donor members of the HDPs (see box 6 for the distinction), vocal proponents of the partnership initiated by the GoU and the sector-wide approach in the health sector.⁷³ I do so as a means of exposing the obstacles to coordination even within a superficially homogenous grouping. The hope is that by highlighting differences here - in *modi operandi*, aid volumes, development objectives, HQ restrictions and even personality - it might be possible

Bigirimana. His presentation was entitled "Public Expenditure Review for the Health Sector in Uganda FY 2003/04-2005/06."

⁷² See Chapter Seven for more detail on the growing importance of civil society in Uganda's health sector as a response to the GFATM and PEPFAR.

⁷³ For an explanation of the SWAp see box 1 on p23-24.

to provide some insight into why coordination between overtly heterogeneous groupings such as donors and government might prove intensely difficult. However, this is not to say that I maintain a naive conceptualisation about the homogeneity of government - I hold with the Walt *et al.* notion that even the abbreviation MoH: “is conceptual shorthand for a number of different players, who may take opposite or contradictory positions” (Walt et al. 1999b: 274).⁷⁴ I am merely concentrating the examination on how a central facet of aid effectiveness rhetoric is being pursued by the aid givers. In doing so, I will also endeavour to posit why, in view of the difficulty of achieving meaningful coordination within a single grouping, the actors nevertheless remain faithful to the ethos. Here I will return to the notion of coordination as a ‘pick and mix’ checklist, and suggest why outwards adherence to the ethos might retain some attraction for donors.

Box 6: Membership of Uganda’s Health Development Partners Group 2007/08

DONOR MEMBERS:

African Development Bank (AFDB)
 Belgian Technical Cooperation (BTC)
 Danish International Development Agency (Danida)
 European Commission
 Italian Cooperation
 Japan International Development Agency (JICA)
 Swedish International Development Cooperation Agency (SIDA)
 UK Department for International Development (DFID)
 United States Agency for International Development (USAID)
 World Bank

NON-DONOR MEMBERS:

Uganda Catholic Medical Bureau
 Uganda Protestant Medical Bureau
 Uganda Muslim Medical Bureau
 World Health Organisation (WHO)

⁷⁴ The GoU is just as divided as the donors, for instance the MoH is being undermined in the budget process by MoFPED and Parliament (Office of the Prime Minister 2008: 40) And although the GoU’s commitment to aid effectiveness is well-evidenced “this commitment is not demonstrated on a continuous basis or uniformly across government or quasi-government institutions” (Office of the Prime Minister 2008: 65).

I turn first to one of the simplest distinctions that can be made between the HDPs at the country level in Uganda: between the *modi operandi* of their health teams.

Donor Differences

Modi Operandi

The working arrangements of Uganda's various donor HDPs on the ground in Uganda are distinctly heterogeneous: ranging from teams where there is a plethora of technical expertise to ones where the sole staff member assigned to health was based outside Uganda. As such, the activities and levels of engagement they demonstrate with regards to the sector and the health partnership contrast widely.

To start with the smallest health teams in terms of staff numbers, one can immediately start by highlighting that it was in the cases of the two multilateral donors to Uganda's health sector – the World Bank and the African Development Bank (AFDB) – that the health representatives were found to be out of the country when approached for comment. The World Bank representative was away for a period exceeding three months in 2008 (World Bank email 17th April 2008) - seemingly with no interim cover - while the AFDB health representative was based in Tunisia for an unspecified period (AFDB email 19th May 2008); although in this instance, the AFDB Country Operations Officer was found to be attending to sector activities in his absence. This staff member however had only been attending to the Bank's health portfolio for a period of two and half months when approached to discuss his involvement in July 2008 and had not therefore engaged in many partnership activities (World Bank emailed questionnaire 14th July 2008).

Certain bilateral donors were also found to have just one representative assigned to health in their country offices; however, in these cases, the salient staff members were found to be present and correct. DFID and SIDA fall into this category, although again certain distinctions can be made between their general working

arrangements.⁷⁵ DFID for example, although having a single health specialist based in Kampala, did appear to have additional administrative support within the country office to assist him. Moreover, although managing the health programme largely unaided, the DFID representative for health had nevertheless accrued additional duties outside of the traditional programme remit. In this way he was found to be operationalising a “silent partnership” with Irish Aid – put simply: informing Irish Aid of developments in the sector in light of its recent withdrawal as part of a division of labour exercise (Irish Aid Interview 2nd April 2007); he was acting as the vice-Chair of the HDP group; and he was found to be the focal person for the AIDS Development Partners (ADPs) Group at the HDP forum. In short, DFID, despite only boasting a one-man health team, was proven to be a very active supporter of Uganda’s health partnership at the time of the fieldwork.

SIDA on the other hand, was found to have just one staff member in-country, charged with managing both SIDA’s health and HIV/AIDS programmes, and this was without any additional administrative support at the Swedish Embassy (although there was some hope that an additional appointment might be made in 2009 to ease this dual workload). As such, at the time of meeting, the SIDA representative was open about having to prioritise involvement in the HDPs over that in the ADPs in the short-term until additional programme support could be found (SIDA Interview 22nd May 2008).

Moving on now to address a two-man donor health team, the fieldwork found that the Belgian Technical Cooperation (BTC) had developed an innovative working arrangement to fulfil its desire to fully engage in the health partnership in country. Thus while the staff member appointed to oversee BTC’s health programme was not himself a technical specialist – he is in fact Deputy Ambassador to the Belgian Embassy – BTC has employed a full-time health economist since June 2006 to participate in the policy, technical and financial dialogue with the GoU and to advise

⁷⁵ JICA also has just one health representative based in Uganda; however as I was unable to meet up with her during my fieldwork I cannot comment on her workload or practical engagement in coordination activities. I failed to make any contact whatsoever with Italian Cooperation or the European Commission during fieldwork; as such I can’t comment on the *modi operandi* of these agencies.

the Attaché at the Embassy on health issues. In this way, BTC was able to take over the Chair of the HDPs in January 2007 - a role it carried over into 2008 – to coordinate and facilitate the activities of the HDP Group. This particular *modus operandi* is evocative of the *Evaluation of the Implementation of Paris*, which suggests that in pursuit of aid effectiveness goals donor country staff will need to develop “skills in negotiation and facilitation in addition to technical skills” (Office of the Prime Minister 2008: 34). As such, BTC employs an expert to meet the technical demands of its health programme and a professional diplomat to deal with what can be the messy business of partnership building.

To address two of the largest HDP health teams now – Danida and USAID – one can again see two wholly different models at work. Danida at first sight appears to have two teams engaged in health sector work in Uganda: the first based at its national Embassy and comprised of just a few staff members, the second situated at Uganda’s Ministry of Health and made of a core team of four technical experts (supported by additional administrative staff).⁷⁶ The latter grouping is known as the Health Sector Programme Support (HSPS) team, and it is the HSPS’s positioning that marks the Danish *modus operandi* out as unique in the Ugandan setting. To elucidate, in spite of the physical division between the Embassy and the MoH teams, the two are tangibly connected, with the Coordinator of the HSPS team based at the Embassy. The impetus behind this unusual set up is explained as follows:

“It is absolutely crucial that the functions of the HSPS Coordinator be separated from the functions of the Senior Technical Advisor...because the latter is part of the MoH organizational structure and will not be in a position to monitor the implementation of HSP II and HSP III. The HSPS Coordinator position will therefore be maintained in HSPS III and continue to be based at the Royal Danish Embassy in Kampala” (Danida 2005: 77).

In short, the section of the team based at the MoH is explicitly concerned with monitoring the implementation of Danida’s strategic plan for the health sector (*HSPS III*), while the division at the Embassy (which includes the HSPS Coordination and a

⁷⁶ Danida’s four technical advisors at the MoH deal with the following areas: primary health care, pharmaceuticals and medicines, and finance. There is also a senior advisor who oversees this team.

program officer) is additionally tasked with monitoring Uganda's national plan for the sector (*HSSP II*).

When asked about the above arrangement, the Danida focal point at the Ministry suggested this unusual set up was but an "interim" capacity building arrangement (Danida Interview 7th May 2008). Nevertheless he made it clear that it was one that had been ongoing for several years. It is indicative of the respect accorded Danida, as one of the "progressive" Nordic donors, that it is permitted to behave in this way – all the while extolling a commitment to country "ownership" and evading charges of neo-colonialism.⁷⁷

In comparison to the other HDPs, Uganda's largest donor USAID would appear to have a relatively small health team if one were to compare the size of the workforce to the scale of USAID's current funding to the sector: it has approximately 20-25 staff members engaged in three programmatic areas. However, as shall be addressed in the later stages of this discussion, this is accomplished by the specific operational model utilised by USAID, which employs private sector companies, civil society organisations and occasionally government bodies to act as "implementing partners" in its development work. As such, USAID has approximately 48-50 "prime" implementing partners on the ground in Uganda that serve to operationalise its vast health programme (USAID Interview 27th March 2007).⁷⁸

To now compare the *modi operandi* of USAID and DFID – Uganda's two largest bilateral donors to Uganda – it should become clear that the size of donor health teams at the field level (which vary wildly) have little correlation to the volume of aid the donor agency contributes to the sector. It may help at this point to highlight the other major issues that serve to belie the homogeneity of Uganda's HDPs.

⁷⁷ Brainard (2007a) reminds us that donors like Danida are not burdened by the colonial history of strategic entanglements in the same way as say, the US. Please see Chapter Six for more information on the Danida *modus operandi* and strategic plan in Uganda.

⁷⁸ "Prime" implementing partners are also sometimes referred to as "prime contractors" because of their ability to engage additional "sub contractors" to implement USAID-funded projects. In this way USAID may actually be funding several hundred organisations in country, while only charged with managing the original 48-50 "primes."

Aid Volumes and Development Objectives

The most obvious difference to demarcate the HDPs relates to the official development assistance (ODA) they each devote to Uganda's health sector: the volume, the modalities through which they deliver it and the objectives they attach to it.⁷⁹

Given that the Paris Declaration is, at least in part, a response to the unpredictability of aid it should come as no surprise to note that up to date data on the breakdown of ODA to Uganda's health sector remains sketchy. As such, the figures I draw upon here are approximations of donor aid commitments as they stood in 2007/8 - the intention being to provide a selection of aid data (as provided by the donor agencies themselves) for the purpose of demonstrating variance.⁸⁰

To start with the biggest health donors, the fieldwork data suggested that USAID's ODA in FY 2008/9 would be as follows: PEPFAR: US \$279 million (USAID Interview 30th April 2008), PMI: US \$22.5 million and an unspecified – though much smaller - volume for other USAID health work.⁸¹ Moreover USAID's funding to the sector – in accordance with US Congressional constraints – will continue to be provided in project form. A representative for the AFDB has suggested that it will be providing an estimated Units of Account (UA) 52 million – again as project support - over the period 2008-10, which is the equivalent of about US \$33.28 million annually (AFDB emailed questionnaire 14th July 2008).⁸²

⁷⁹ Walt *et al.* (1999a) confirm that the ideal to coordinate aid is constrained by the differing objectives of the different actors.

⁸⁰ A good resource for comparing aid flows between donors is of course the OECD/DAC Creditor Reporting System. Yet, it is acknowledged that even there the quality of data is only as good as the information the donors provide. For the purpose of this discussion, I have opted to use self-reported data on aid to Uganda, as provided by the donors. The list is not intended to be comprehensive, only to illustrate variance.

⁸¹ USAID's general health sector remit in Uganda covers: child survival, family planning and reproductive health, neglected tropical diseases, health systems strengthening and Avian Flu (USAID Interview 13th May 2008).

⁸² "ADB financial statements are expressed in UA, or Units of Account, whose value is defined as about 0.8887 grams of fine gold. As of 2001, 1 UA equals approximately US\$1.28" http://en.wikipedia.org/wiki/African_Development_Bank [Accessed 14th December 2008].

DFID's bilateral health programme awarded Uganda £8,548,000 in FY 2008/09, of which just over half - £4,550,000 was termed "Notional Allocation of General Budget Support to Health" or Poverty Action Fund budget support (Freedom of Information response from DFID 18th December 2008).

SIDA takes a different view to describing its aid flows to the sector, by relaying the expenditure on health for the prior year as opposed to future projections, which it finds "more interesting"; thus for 2007 the annual expenditure for health was said to be approximately US \$14.5 million, of which 75% was provided as Poverty Action Fund budget support, 10% went to projects and 15% went to civil society (SIDA Interview 22nd May 2008).

Finally, taking BTC as the last example, it was found to be awarding the health sector around 4 million Euros – or just under US \$5.5 million annually - which it delivered predominantly as Poverty Action Fund budget support (BTC 2007).

Clearly therefore, there is massive diversity in the volume of ODA that Uganda's HDPs award its health sector and in the proportions of aid channelled through different modalities. Yet, what about the specific objectives the HDPs attach to their aid? While it's relatively easy to determine the thematic areas that project-based donors such as USAID and AFDP prioritise in Uganda's health sector – USAID is directing the majority of its funding toward HIV/AIDS and malaria-prevention/eradication activities while AFDB favours maternal and mental health inputs – it is useful to note what the HDPs who provide the majority of their funding as Poverty Action Fund budget support list as their thematic priorities (see box 7 for an overview).

Box 7: Declared Sector Objectives 2008 by Donor Agency

AFDB	Maternal health Mental health
BTC	Primary Health Care Conditional Grant Contribution to HDP Partnership Fund Salary of BTC health economist
Danida	Support to district health services Support to districts in the north Central-level support to Ministry of Health Support to the training of enrolled comprehensive nurses in private-not-for profit schools Pharmaceutical sector support
DFID	Health policy and administrative management Basic health care Infectious disease control Health education Health personnel development Reproductive health Maternal and neonatal health HIV/AIDS including sexually transmitted disease prevention
SIDA	Sexual and reproductive health/rights Maternal health Human resources for health HIV/AIDS
USAID	HIV/AIDS Malaria Child survival Family planning and reproductive health Neglected tropical diseases Health systems strengthening Avian flu

BTC sector budget support has three components: a grant to the Primary Health Care Conditional Grant - which finances *HSSP II* implementation in the districts, a contribution to the Partnership Fund and the salary of the health economist employed as BTC's technical expertise in the health sector (BTC 2007).⁸³ SIDA's priorities in the sector are sexual/reproductive health and rights, maternal health, and human resources for health (SIDA Interview 22nd May 2008). DFID has a comparatively large health remit targeting: health policy and administrative management, basic

⁸³ See Chapter Five for explanation of the Partnership Fund.

health care, infectious disease control, health education, health personnel development, reproductive health, maternal and neonatal health and HIV/AIDS including sexually transmitted disease prevention (Freedom of Information response from DFID 18th December 2008). Finally, Danida's programme has five integral components: support to district health services, support to districts in the north, central-level support to the MoH, support to the training of enrolled comprehensive nurses in private not-for-profit schools and pharmaceutical sector support (Danish Ministry of Foreign Affairs 2005).

In sum, while certain aspects of HDP health programmes demonstrate a degree of crossover, a breakdown of the thematic areas underscores how different their priorities actually are on the ground. Of course, in one way this serves to satisfy the facet of aid effectiveness rhetoric that discourages duplication. Nevertheless, the question remains as to how successfully these key thematic differences are ironed out at the country-level when the HDPs are forced to reach common positions on Uganda's various health issues? I will return to this question in due course. However, before I do, the following anecdote from a new donor representative to join the HDP Group in 2007 is perhaps insightful:

“We are sitting there around a table and we're supposed to find our common views on government issues and to get our ideas you know, together for our one consolidated development partner view...position, and I don't even know what the others are doing in their programmes, what are their goals, why are they here? And I think that's very poor. And of course at the same time...you know when you're new you tend to be a little: 'Oh, I can't bring this up because they probably talked about this a couple of months ago.' But now when I start talking to people everybody's saying: 'No, I don't know what the others are doing. I have no idea'" (SIDA Interview 22nd May 2008).

Could it be therefore that maintaining largely superficial relations at the country level, which serve to gloss over difference, is actually one tool of an effective coordination strategy?

Headquarters and National Politics

A major finding of both the *Evaluation of the Implementation of the Paris Declaration in Uganda* (Office of the Prime Minister 2008) and the *Paris Synthesis Report* (Wood *et al.* 2008) was the following:

“No matter how well developed the country systems and procedures...it is noted that some donors are still reluctant and/or formally constrained in using country systems due to policies and restrictions imposed by their headquarters and continuing concerns about fiduciary risks” (Wood *et al.* 2008: 15).⁸⁴

Moreover that:

“without the political will at higher levels, many DPs [Development Partners] contend that the framework for strategy and programming around the Paris Declaration principles would not exist and country offices remain stifled, even though their counterparts may be making much more progress” (Office of the Prime Minister 2008: 41).

In short, the reports highlight two additional factors that could be serving to undermine meaningful partnership at the country level in Uganda: diverging political agendas which impact on the level of engagement advocated in partner countries by national headquarters (HQs), and a subsequent disconnect between field office staff and their HQs – who may begin to subscribe to very different levels of engagement as a result of their contextual vantage points. I would suggest that the main issue behind this disconnect, and the key factor discouraging full compliance to the principles of alignment and harmonisation at the country level in Uganda is one I have already touched upon in this discussion: concerns over governance.

Differing perceptions over the risk posed by alignment and harmonisation around Uganda’s existing institutional structures remains a source of contention between different donor agencies at all levels and one unlikely to be resolved in the

⁸⁴ The *Paris Synthesis Report* presents a synthesis of 19 separate evaluations of the implementation of the Paris Declaration during Phase One in 8 partner countries (including Uganda) and 11 development partner/donor agencies. All contributing partners were self-selected and different methodologies were used for each (Wood *et al.* 2008: 2-3).

foreseeable future. Moreover, as the context chapter in this thesis has already highlighted, Uganda's donors have good reasons to question the integrity of Uganda's systems; following the mismanagement and misappropriation of both GAVI and GFATM funds in 2005/6, President Museveni's revision of term limits in 2005 and the shaky transition to multi-party politics in 2006, donors have been increasingly questioning Uganda's status as a 'donor darling' (Atoo 2005; Barkan 2005). Furthermore, despite a fairly stable couple of years, frustration over the delay in securing prosecutions for the misappropriation of funding is palpable; a point that finds a mention in Uganda's *Paris Implementation Report*, when the reluctance of donors to move toward unconditional budget support is explained as follows: "DPs find it difficult to justify BS [Budget Support] to their taxpayers when corruption is rife and reported cases go without investigation" (Office of the Prime Minister 2008: 47).

Considering that Uganda's UJAS donors were already conflicted over corruption concerns when devising their strategy in 2005, it is easy to understand why developments in the country since then have only served to vindicate an already cautious engagement. Indeed, while certain countries like Ireland and the UK reduced their aid to the country in 2005 in reaction to the developments at the time (O'Farrell 2005; <http://www.dfid.gov.uk/news/files/pressreleases/uganda-reduction.asp> [accessed 19/12/08]), the fieldwork revealed that following the spate of disorder, SIDA had actually considered withdrawing aid from Uganda altogether (SIDA Interview 22nd May 2008). And of course in February 2010, Uganda's Local Development Partners Groups threatened to withdraw ODA on masse over continuing concerns over corruption and impunity for corruption (Observer Media Ltd 2010).⁸⁵ In short, if an unequivocal commitment to the principles of aid effectiveness could be viewed as a strategy that might serve to heighten the level of risk incurred through aid giving, then one can begin to understand why donors tend to pick and choose from the different facets involved in the coordination checklist, leaving out those that would see them ceding the most control over aid to the partner country, like general budget support. This is evidenced first by the aid giving

⁸⁵ This incident is documented in Chapter Two.

strategies of the HDPs – who favour project aid and/or providing budget support via the ring-fenced Poverty Action Fund - and second by the fact that the division of labour exercise initiated in Uganda was depicted by Development Partners as applicable: “in all other cases except in the field of governance, where donor selectivity would result in a weak voice” (Office of the Prime Minister 2008: 15).

Turning now to look at the most overtly risk averse of the bilateral donors – USAID – one can see how the United States (US) micromanages its aid to Uganda, while all the while affirming a serious commitment to the aid effectiveness agenda.

The US provides a good case study to illustrate not only some of the activities employed in averting the risks associated with aid giving, but also the consequences of this from the standpoint of field staff at the country level. The Congressional constraints affecting US aid are well documented and, in light of the intransigence to change demonstrated by the numerous failed attempts to seriously reform the 1961 Foreign Assistance Act (Nowels 2007) they are unlikely to be revoked in the foreseeable future. Nevertheless, the volume of aid the US has been allocating to health through its global initiatives the President’s Emergency Plan For AIDS Relief (PEPFAR) and President’s Malaria Initiative (PMI) has risen drastically in recent years, demonstrating a revised faith in the utility of bilateral development assistance for furthering US concerns abroad (Riddell 2007).⁸⁶ I stipulate ‘bilateral’ because as Brainard points out, multilateralism does not sit well with the US – it is too impatient and too important to work with partners. This is well exemplified in the launching of PEPFAR just two years after the US government committed its support to the GFATM (Brainard 2007a) and the finding that just 10% of US foreign assistance was channelled via multilateral institutions in 2003 (Riddell 2007: 57). It is perhaps interesting to ponder therefore, that despite Congressional restrictions – for instance, earmarking ODA and precluding US foreign assistance being provided as budget

⁸⁶ Riddell reminds us that post 9/11, the 2002 *National Security Strategy* promoted development to become the third pillar of US Foreign Policy, alongside defence and diplomacy. Indeed, that: “The primary purpose of United State’s aid has always been to further and promote its own interests, with foreign aid an essential arm of foreign policy, with massive amounts of aid channelled to America’s allies. As a result, foreign aid allocations have always been critically influenced by national security priorities. However, within this broad framework, development and humanitarian goals have also been important.” (Riddell 2007: 94)

support in countries with poor governance ratings - the US is a signatory to the Paris Declaration. The *Paris Implementation Report*, while understanding of the restraints placed on US aid, notes that this stance creates a somewhat conflicting image of the donor in the Ugandan setting:

“Some donors speak the language of the PD but in practice disagree with some of the principles, especially the use of country systems...For some DPs...the principles on which they were established, and the general conditions that govern their operations would have to be reformed first before they can be able to use country systems” (Office of the Prime Minister 2008: 38).⁸⁷

The consequence of this for country staff at USAID is pronounced. While other donors continue to use a mix of aid modalities without apology, USAID’s sole employment of project aid in the Ugandan setting provokes open criticism from its peer groups, which one staff member termed “tiresome” and a “waste of energy” when it wasn’t an issue she was even empowered to act upon. Her view was that it would be more constructive for all involved if everyone could just accept the status quo and make it work as best they could (USAID Interview 30th April 2008). Another USAID interviewee agreed that the staff got tired of defending themselves over the same issue yet at the same time suggested that such criticism tended to be voiced in public - for show - and that her personal one to one relations had always been fine (USAID Interview 13th May 2008). This is an interesting point and one to be explored in the next section, when I consider how donor coordination may be influenced by individual personalities at the country level. First however, it is worth

⁸⁷ Brainard has also underscored the discrepancy between the reality and promise of the US’s commitment to aid effectiveness, noting “Unfortunately, in the United States, there is a tension between implementation of these [PD] principles and congressional and public support for a sectoral approach to assistance...” (Brainard 2007a: 12). Moreover, that “At a time when coordination of assistance among donors has been recognized as one of the most importance principles for increasing aid effectiveness, the United States appears to be moving in the opposite direction (Brainard 2007b: 39-40). He highlights some of the significant barriers to the US honouring the harmonisation and alignment tenets, noting that “coordination in the field looks enviably simple when compared with the overlapping jurisdictions in Washington” (Brainard 2007b: 33) (there are twenty organisations involved in the provision of US foreign assistance, each with competing objectives); and that “The current system defies basic management principles by separating policy from operations and both from budgeting” (Brainard 2007b: 44). To focus specifically on the PEPFAR programme, the need for attribution of results and Congressional earmarking both undermine USAID’s ability to realise its Paris commitments (IOM 2007). The issue of earmarked aid is tackled in more detail in Chapter Six.

noting some of the other ways USAID has devised to be seen to pursue aid effectiveness goals, while staying within the confines of its national policy.

Despite being outside of the UJAS framework, USAID has introduced a periodic aid effectiveness monitoring survey to be carried out for all its overseas missions, the results of which it disseminates on a website where US citizens can direct questions at government; thus presumably increasing the accountability of US aid. Moreover, it has employed focal persons to support the completion of the survey who coordinate the collection of the data and clarify the definitions of the aid effectiveness indicators used, thus raising the profile of the aid effectiveness agenda throughout its field staff (Office of the Prime Minister 2008: 39). Furthermore, in addition to the activities that directly relate to the signing of the Paris Declaration, the USAID team also engages in each of the coordination forums in Uganda health sector that pre-date the Paris commitment – the technical working groups, the HDP Group, the ADP Group and the HPAC – and has even offered to lead the HDP Group as part of Division of Labour Exercise in 2009. Finally, although not necessarily a regular occurrence, the PEPFAR programme aims to hold an annual PEPFAR Dissemination and Stakeholders Consultation to allow Uganda’s health stakeholders and implementing partners to feed into the future plans of the fund.⁸⁸ They do this through panel sessions and break out groups aimed at identifying ways the fund could perform better and priority setting.

Yet just how meaningful USAID’s participation can be in such forums when its agenda is set elsewhere and its interventions run parallel to national systems is questionable.⁸⁹ The *Paris Report* reveals that the US had at one time expressed an interest in joining the UJAS; however the amendments it suggested – which challenged both the primacy of budget support and the rationale for using country

⁸⁸ I was invited to attend this meeting on 3rd May 2007. By mid-2008 however it wasn’t clear if it would take place that year.

⁸⁹ Brainard highlights the disconnect between the US field staff and their Washington counterparts when he notes that “Currently, there is clear separation of policymaking from implementation for a large share of foreign assistance programming.” This set up “assumes that aid decisions can be made solely on the basis of policy considerations – such as U.S. objectives – without regard to the technical aspects of the particular sectoral or functional activity or to feedback from implementers in the field” (Brainard 2007b: 44).

systems – were turned down and saw its interest dwindle. Given that the majority of the HDPs are UJAS members, or at least in favour of earmarked budget support, it seems that the US position might be too diametrically opposed to that of the other donors to facilitate meaningful partnership at the country level. Moreover, in light of other strong criticism directed toward the USAID programme in Uganda during the fieldwork period, one can begin to discern another reason why the USAID Uganda team may have been disadvantaged by the decisions made by HQ over its head.

The fieldwork revealed that criticism directed at USAID's involvement in Uganda's health sector was stimulated by a more complex issue than its continued refusal to deliver aid as budget support. The finding that the majority of US project support was considered "off-budget" was just one part of the puzzle.⁹⁰ Another was the *Annual Health Sector Performance Report* finding that where project aid was being spent in the private sector it had a doubtful alignment to *HSSP II* priorities (MoH 2007a). The final piece of the puzzle came following various ambiguous remarks made at sector forums, which were explored during interviews at Uganda's Ministry of Finance. Here, the interviewees alluded to a funding agreement between the US and the GoU to accept aid that fails to demonstrate alignment with sector priorities; moreover to have that money channelled via a lead agency appointed by the donor, rather than the MoFPED. This was the arrangement being used for PEPFAR money at the time of the fieldwork, and in his explanation of it, one interviewee alluded as to why it might prove unpopular with Uganda's other HDPs:

"What the PEPFAR money is, is off-budget. Therefore it is rather big. We don't know what it's spent on for instance and which unit costs USAID is following – the expenditure units. We don't really know what they're spending the money on. We can't tell how much money comes into the country even. But we know we've signed an agreement" (MoFPED Interview 25th April 2008).

⁹⁰ Off budget or ex-budgetary aid – means aid not captured under Mid-Term Expenditure Review sector ceilings. Even project aid should be captured in MTEF ceilings under the GoU-HDP agreement; because even if it's not being channelled through Uganda's financial systems, the information on the aid should be used for central level planning in the sector to minimise waste and duplication.

The *Paris Implementation Report* also hints at this kind of arrangement when it suggests that project support is undermining the GoU's leadership of the development process, saying that this applies mostly to projects:

“approved at a higher level than the sector concerned, or by those development partners who neither have joined the UJAS nor signed the Partnership Principles and whose projects do not get discussed by Sector Working Groups prior to approval” (Office of the Prime Minister 2008: 42).

Asked why such an exception might have been made to accept the PEPFAR money in light of the GoU's own stated preferences in the *Building Partnerships* document (2001), the MoFPED interviewee suggested that “the reality is we have got the financing gap and we welcome any support that could alleviate the gap in the interim” (MoFPED Interview 25th April 2008). The contradictory situation the PEPFAR money forces the GoU into recalls the work of Lewis and Mosse (2006), whereby the GoU should be regarded as a skilled aid ‘broker’ rather than a victim for allowing such a deal to exist.

Van de Walle and Johnson have argued that until “governments are willing to turn down aid that is granted through channels that undermine government coordination, donors will continue to use the channels that suit them best” (Van de Walle and Johnson 1996: 110). Yet in this finding one is reminded of the unequal aid relationship that persists between partner and donor countries, which means that money can still buy loopholes in even the most well established partnership agreements.⁹¹ It is an unequal balance that undermines the more tricky tenets of aid effectiveness like transparency and alignment, and shows that meaningful coordination remains a checklist where even the most superficial compliance – in the form of an aid effectiveness survey – can be reported as overall adherence.

⁹¹ Partnership Principle 4 commits the Ugandan government to refusing any stand-alone projects. This means it should be turning down any projects which are off-plan (i.e. when it cannot ensure the project is contributing to sector priorities) and/or off-budget (i.e. when the precise volume and use of funding is unknown, meaning the government cannot factor it into the Medium-Term Expenditure Framework). All of PEPFAR's projects in Uganda are ostensibly off-plan and off-budget, and as such, should be refused.

Remarkably, having in the later stages of the fieldwork shed some light on the PEPFAR funding pact with the GoU, many of the comments that had emerged during the earlier stages began to gain new resonance; because while the PMI programme seemed to be viewed quite favourably by malaria partners in-country, the PEPFAR programme repeatedly evoked strongly-worded criticism. For example, one interviewee at WHO cited the USAID/PEPFAR team's apparent disinterest in forging partnerships beyond that which it enjoys with Uganda's AIDS Commission as evidence that "the US is the Minister for Health for HIV/AIDS in this country... Yeah, they are too much, they are too much" (WHO Interview 7th November 2007). While a government official said of USAID "They're bullies," in the context that they still refused to inform the MoH of all the activities they were funding in the sector (MoH Interview 7th April 2008).

A final salient interview excerpt recounts an incident where the Chair of the HDPs depicted the USAID field staff as "passive participants" in sector forums and underlined his disappointment that USAID had shown no interest in putting itself forward as a 'Lead' of the health sector as part of the division of labour (DoL) exercise being undertaken in the health sector. While elucidating on why he thought this might be the case - which included suggesting quite logically that USAID's remit to manage all its implementing partners in country might preclude such an engagement - the interviewee made all manner of allusions as to how the US were funding Ugandans working in security firms in Iraq and training troops for Somalia - in sum, serving to blur the distinction between the objectives of US foreign aid and the actual USAID health programme in Uganda (BTC Interview 10th April 2008). Yet, the inaccuracy of this interviewee's earlier conjecture was revealed less than three weeks later when a senior interviewee at USAID explained that USAID had just put itself forward to assume the 'Lead' of the health sector for 2009, thus showing its commitment to being an active participant (USAID Interview 30th May 2008).

The staff I encountered at USAID in Uganda were very upbeat and philosophical about the prejudice facing the US foreign aid programme. Nevertheless one can only

imagine the true frustration they feel when, despite their best efforts at the country level to facilitate successful health programmes and to forge fruitful alliances with partners, they find themselves discriminated against and hindered by decisions over which they have no control, and for which they will nevertheless become the default focal persons for blame.

USAID presents the most extreme example of a donor agency whose staff at the field level are constrained as a result of policies, political pacts and HQ restraints determined far above their heads. However, it's clear that all donor agencies have their own peculiar rules and constraints, devised in their national settings and over which staff based in partner countries will have little or no capability to overturn (Crewe and Harrison 1998).⁹² It is these sorts of restrictions that cause the disconnect between HQs and field offices identified in the *Paris Implementation Report*, and which has resulted in the suggestion that there needs to be a greater delegation of responsibility to field office staff if aid effectiveness goals are to be achieved.

Some additional everyday factors, highlighted in the *Paris Report*, and with the potential to curtail the potential of field staff to participate meaningfully in coordination activities at the sector level include such things as: uncertain funding cycles which undermine the “timeliness and predictability of aid disbursements” to Uganda (Office of the Prime Minister 2008: 45); diverging views at HQ over the extent to which donors should feed into policy discussions with national governments; and of course the contrasting preferences donor agencies demonstrate with regards to the proportion of aid they allocate through different modalities.

During this section of the discussion, I have attempted to expose several of the main differences that serve to belie the homogeneity of the donor subset of the Health Development Partners Group in Uganda. These have been identified broadly as differences in *modi operandi*, aid commitments, aid objectives, strictures from headquarters and national politics. Furthermore, using a case study of USAID, I have

⁹² Chapter Four recounts some of the legal restrictions governing Uganda's bilateral donors, which have affected dictated how the new Civil Society Fund will to be managed.

sought to demonstrate how such differences can serve to mitigate a donor's engagement with aid effectiveness commitments at the national and international level, and how this mitigated engagement can impact on in-group relations. The broad aim in providing this overview has been to allude as to why meaningful partnership between Uganda's health donors and the overtly heterogeneous stakeholder sub-groups in the sector (government, civil society etc) may currently represent an unattainable ideal.

In the next section, I discuss some of the strategies Uganda's Health Development Partners have developed to try and overcome their differences and question why, in light of the difficulty of the task they have set themselves – to reach common positions and speak with “one voice” at joint sector coordination fora – they persist in the illusion that they are a coalesced grouping.

Dealing With Difference

To tackle the issue of coordination fora first, it should be noted that prior to their monthly participation at the most important multi-stakeholder forum for the sector - the Health Policy Advisory Committee – Uganda's health donors meet together as the Health Development Partners Group, together with other stakeholders who have also attained the status of “HDP” (representatives from the World Health Organisation and Uganda's Religious Medical Bureaus).⁹³ All in all the grouping probably averages around 15-20 members, who are all focal persons from the signatory organisations to the original 2000 MoU with the GoU. In addition, other visitors may occasionally be invited by the HDPs to attend, for instance to provide supplementary technical expertise.

The Terms of Reference (TORs) for the HDG Group tell us that its purpose is to provide a more formal forum for coordination between the Development Partners

⁹³ The role of Uganda's religious medical bureaus in Uganda's health sector and their differentiation from civil society organisations is dealt with in Chapter Seven.

working in health; to reduce transaction costs for both agencies and Government in implementing the *Health Sector Strategic Plan*; and to strengthen the partnership between the GoU and HDPs to ensure more effective implementation of the *HSSP* through the SWAp process.⁹⁴ Specific functions include enabling partners to “coordinate and collate joint responses to issues in the sector...” and providing “a means by which the partners can communicate amongst themselves and with the Ministry of Health more effectively” (HDPs 2006: 2.3.ii & iii). To facilitate the joint responses to be issued to the MoH or at sector forums, the HDP Group appoints an annual Chair from its membership to act as the focal point for the group. That is not to say other members are not allowed to speak at the sector forums, only that they try to adhere to the mechanism they themselves have devised. In instances where there is a minority view, the TORs allow that it too will be represented to the MoH.

During the fieldwork the literal translation of this idea of the HDPs speaking with “one voice” was witnessed at various sector forums, such as the Joint Review Mission and the Mid-Term Review of the *HSSP II*.⁹⁵ On these occasions, a joint HDP statement would be read to the group by the appointed chair, with no deviation from the written statement. In this way the impression of the HDPs’ common position was maintained.

Clearly the idea of partners reaching a common position is very much in keeping with the idea of harmonisation promoted in both Rome and Paris Declaration; however, I would suggest that this behaviour - beyond saving time at sector forums and minimising waste and duplication - boasts additional benefits for development partners interacting with a domineering government; for instance, for the purpose of attaining strength in numbers.

An example from the fieldwork suggests that strength in numbers – attained by creating the semblance of unity – may offer some protection from the tactic of divide and rule the GoU has sometimes utilised against its partners. In Chapter Seven, I

⁹⁴ The HDP Terms of Reference are included as Appendix 4.

⁹⁵ I attended the Joint Review Mission from 24th–26th October 2007 and the Mid-Term Review from 27–29th May 2008.

recount an incident whereby donor partners were found to be taken advantage of as a result of having coordinated themselves poorly whilst developing a new basket funding mechanism for civil society. In this instance, certain government bodies were said to have attempted to divide and rule the partners, although to no serious effect in that instance beyond wasting time. Yet it is remarkable on that occasion, the donors were not in fact organised under the auspices of the “HDP group” but instead acting independently of the grouping, as individual agencies within a broader network.⁹⁶

In contrast, when they have operated within their coalition, the donors do appear to have had some degree of success in forcing the government’s hand. This practice is alluded to in the *Paris Implementation Report* when certain government officials are suggested to been reconsidering their preference to receive aid as budget support:

“some reports point to the waning popularity of BS [budget support] at higher political levels. This development stems from recent threats of some UJAS partners...to use BS not only as a ‘carrot’ for good governance, but also a ‘stick’ in the event of poor performance. This threat, which has become even more prominent with greater collaboration and harmonization of donor strategies through the UJAS, has back lashed in declining local political support for it and fuelled scepticism about donor intentions within the UJAS process” (Office of the Prime Minister 2008: 47).⁹⁷

Indeed, as the context chapter of this thesis has made clear, the GoU’s concern over budget support emerging as a “stick” has been realised in Uganda, with the Local Development Partners Group threatening to withhold joint budget support en masse in response to concerns over governance (Observer Media Ltd 2010). That budget support could evolve into such a double-edged sword for GoU points again to the unexpected consequences of new aid initiatives (Walt *et al.* 1999b).

⁹⁶ In a similar vein, the HDPs have complained about a lack of coherent strategy for the GoU to solicit technical assistance; in this way different donors have been asked by their government partners for similar inputs, contributing to waste and duplication in the provision of TA. Clearly therefore, a framework which forces the GoU to approach the HDP group for TA would reduce wastage and permit the donors to see if they’re being taken advantage of.

⁹⁷ On the other hand, “some government stakeholders believe that the Paris Declaration gave them a stronger hand in dealing with development partners” (Office of the Prime Minister 2008: 27).

It appears the commitment to coordination may boast a second advantage for Uganda's HDPs: by fostering the mutual sense of responsibility and trust required to see informal lending occur between the partners. Here, I refer to the practice of donor bridging loans at the country level, which while not well publicised, do occasionally transpire (GFATM 2006; Oomman *et al.* 2007). This was confirmed for me in the Ugandan context when it was recounted that USAID/PMI had stepped in after a particularly arduous funding chain involving two of the other HDPs had temporarily stalled, endangering the country's plans to commence Indoor Residual Spraying during the summer. To expand, the original agreement had required funds to pass from DFID, to WHO, and finally to the Ministry of Health (i.e. the implementing partner). Yet a delay in the chain had meant the money had failed to make its way to the MoH in time. This prompted USAID/PMI to step in – it not only advanced funding but also arranged that the spraying be commenced using insecticide it had already acquired (and which it was explained, was soon due to expire). The understanding thereafter was that USAID/PMI would be reimbursed for the money and the insecticide after the original funding chain had completed (USAID Interview 31st July 2007).

Such a bridging loan bodes well, even for the 'pick and mix' version of the coordination ethos identified in Uganda. The drive to coordinate literally stimulates HDPs to stay in regular contact, providing the opportunity to flag up potential problems and to develop faith in one another's system, which is exposed as a huge advantage when the need for mutual assistance arises. Indeed, the incident recounted here only serves to confirm the suggestion that there is a disconnect between headquarters and the field offices of donor agencies (how else to account for the missing funds?), a disconnect which this incident tells us may be part compensated for through good peer-to-peer relations. For example, it makes sense that by virtue of their shared vantage point, partners in-country would agree that Indoor Residual Spraying should be commenced on a particular date and not simply put off until the aid filters through (something a donor HQ may not appreciate). Moreover, it's a happy aside that agency field staff, themselves no doubt well used to butting heads

with their own HQ, would become predisposed to assist their in-country partners, at least when able to do so. Thus while donor bridging loans may not be a regular occurrence at the country-level, their very existence is a welcome sign – particularly in relation to health aid - pointing to a shared concern in the intended beneficiaries of the aid, a sub-grouping too regularly de-prioritised during conflicts over internal bureaucracy.

A third advantage to the version of coordination practiced by Ugandan's HDPs is one that relates most clearly to the provision of budget and sector budget support, but also arguably to the provision of well-aligned project aid: the ability for HDPs to claim a share in the attribution of sector-wide results in the health sector. Thus instead of having to measure impact and account for every penny (and ignoring the numerous confounding factors that can help or hinder a health intervention's success), donors can cite impact for their aid using national reports such as Uganda's *Annual Health Sector Performance Report* (AHSPR) (MoH 2007a), and more ad hoc ones such as the *Demographic and Health Survey* (UBOS and Macro International 2007). And indeed they might, when HDPs provide the lion's share of funding to produce such publications. Thus while the costs of regular reports – such as the AHSPR - are covered by the HDP's Partnership Fund, funds for publications like the Demographic and Health survey are readily topped up by Uganda's donors, who in turn enjoy a well-placed logo and a mention on the inside cover.⁹⁸ Yet the logic in claiming joint attribution goes beyond the practical difficulty of chasing donor dollars from general budget to end beneficiary. If one accepts that statistics are a prerequisite for the flow of development aid, then the shared attribution of results is a huge advantage of the coordination ethos for all partners at the country level, HDPs, GoU and civil society alike.

Having previously suggested that maintaining a semblance of unity in the face of the sometimes domineering GoU has the utility of giving the HDPs an increased sway in

⁹⁸ For example, the *Uganda's Demographic and Health Survey 2006*, while produced by Uganda Bureau of Statistics and Macro International, was financially supported by: USAID/Uganda Mission PEPFAR, DFID, the GoU, the Health Partnership Fund, UNICEF, UNFPA and the Government of Japan (UBOS and Macro International 2007).

sector discussions, I would now like to posit that the very etiquette of speaking with “one voice” is just one of a set of quite bureaucratic processes that Uganda’s HDPs have adopted through which to project a notion of commonality. Through these means the donors can focus on a shared set of behaviours and procedures, which serve to detract from and to mask their differences. These include such things as the Memorandums of Understanding, TORs, the Partnership Fund and the formal etiquette donors adhere to in group arenas.⁹⁹

Several interviewees hinted at the central - seemingly disproportionate - emphasis that is placed on managing processes at the HDP Group meetings. For example, one interviewee was exasperated by the undue attention being paid to ensuring accountability for the Partnership Fund when vast aid sums given elsewhere in the sector went missing without explanation:

“We do put in money to that [Partnership Fund]. And as far as I’m concerned I think that’s a total waste of...not a waste of money but that little kitty...so here [Uganda] all sorts of funny things go on and we don’t really know what’s happening with all of our money, including the PAF money which is all donor money, and then we hold onto a very small kitty of money and insist that the Chairman has to counter sign the cheques (Danida Interview 7th May 2008).

Another donor representative underlined that she had initially been quite dismayed by all the administration and processes involved in her work in Uganda, which seemed somewhat at odds with the job advert she had responded to:

“I feel it’s more relations with the other donors and going to meetings, and of course also sitting here and reading all these mails and getting things done, decisions, contracts – it’s a lot of administration and stuff. So I feel until now...I really haven’t seen so much of the country and the health problems, I haven’t talked to people out in the huts about their problems and this is what I really, really miss” (SIDA Interview 22nd May 2008).

⁹⁹ The Health Partnership Fund is discussed in more detail in Chapter Five. Its existence is also alluded to in the Terms of Reference for the Health Policy Advisory Committee in Appendix 5. For now it is suffice to say that the Partnership Fund a donor-funded kitty, intended to cover the administrative costs of managing the HDP-GoU partnership in Uganda.

Finally, one interviewee suggested that her experience of attending the HDP Group was to get lectured by the Chairman about processes before going to the HPAC for discussion, after which decisions were made behind closed doors at the top management level (USAID Interview 13th May 2008). This is an interesting point, and indeed, I would suggest that the utility of such bureaucratic processes – their utility in binding disparate partners together - is in fact derived from their inherent lack of consequence, which is why the partners find it possible to reach agreement over them.

As suggested in an earlier section, the key to maintaining aid partnerships could be to keep them on a superficial footing; that way no party finds itself inextricably bound to another or to a set course of action. This is demonstrated through the Memorandums of Understanding the partners have agreed upon in the health sector. Indeed the first section of the 2005 MoU opens with the line: “This Memorandum of Understanding is not a legal document but reflects the commitment of all parties, who recognize it as guidelines...” (MoU 2005: 1) - it is this line that basically sets the tone of the GoU-HDP partnership.

The Chair of the HDPs offered this insight into his own experience of developing a MoU in Uganda:

“Don’t forget the MoU is not a legally binding document. And it’s sometimes a pity that it is not but it is necessary...in order to get such a diverse spectrum of donors with different procedures, with different legal obligations - like still exist in the US law that American Development Cooperation money cannot be used for budget support, it’s still there; even if they would like to they’d have to change their law first...And the World Bank they don’t want in this kind of MoU too many political orientated articles - they say, ‘Politics is not our business’ - but they are an important donor so you want them on board. So in order to finally reach agreement on a document that everybody is ready to sign you dilute of course the obligations, and any MoU supporting a sectoral plan has to start more or less with that sentence: “This is not a legally binding document” (BTC 10th April 2008).

Moreover, the HDP Chair confirmed that – as with the 2001 ‘Partnership Principles’ - there are no repercussions for partners who fail to comply with the MoU.

In short therefore, my argument is that aid relationships between Uganda's HDPs are kept intentionally superficial at the present time. This is supported by the numerous key differences in funding, *modi operandi*, risk aversion, legal restrictions etc, which serve to actively preclude donors from meaningful engagement with their peers. And it is in response to this – as yet - insoluble situation that HDPs at the field level in Uganda have devised all manner of bureaucratic devices to derive the advantages of coordinated action, while circumventing the risks involved. These have the dual benefit of creating the façade of coordination (external partners will see that the accoutrements of partnership are in place: the MoUs, Terms of Reference, Partnership Funds, meeting minutes etc) and in binding the disparate partners together around a set of – crucially - risk-free processes and behaviours.

The *Paris Synthesis Report* suggests that new incentives are needed to achieve greater compliance to the principles of aid effectiveness. Furthermore, that the incentive structures currently in place are actually proving detrimental:

“In terms of direct incentives, donor personnel are generally committed to the Paris Declaration, but their performance is often measured in terms of their own corporate results frameworks, sometimes coming back to the delivery of inputs or outputs – i.e. short term results” (Wood *et al.* 2008: 23-24).

I would suggest that a revision of the incentive structures in place for field staff may also be one way to improve the levels of engagement both within the HDP grouping, and across the HDP-GoU partnership, because as established, while donors agencies will not submit to there being any negative ramifications from other partners for non-compliance to aid effectiveness commitments, their *modi operandi* do not preclude positive reinforcements within their own organisation. Indeed, the basic logic behind developing an incentive structure was intimated to me by a SIDA interviewee, who told me about SIDA's 'Dialogue Strategy' for Uganda. As part of the strategy, the donor agency is compelled to set dialogue targets, suggesting which partners it would like to interface with, and to what ends. The upshot of this was that SIDA staff could claim “impact” on behalf of their coordination activities (SIDA Interview 22nd May 2008) which, if emulated by other donor agencies, would surely be a welcome

change to field staff having to solely demonstrate impact on behalf of their development aid.

More resources to supplement coordination activities – in terms of man hours and trainings - would also be a positive reinforcement for donor field staff to coordinate at the country level, recognising at last the increased workload they've inherited in tandem with the aid effectiveness agenda (PEPFAR, World Bank & GFATM 2006).

The lack of forward planning that has gone into considering how aid effectiveness rhetoric should be best operationalised at the country level (from all the Paris signatories) is another sub-text to the difficulties facing heterogeneous partners to meet all the requirements of the coordination checklist. This was demonstrated during the donors' initial attempts to undertake a Division of Labour Exercise (DoL) in Uganda, when it was noted that some lower level staff were actively against the idea of reducing overall sector involvement for fear of losing their jobs; moreover that sectors had not been assured that their overall funding would be remain at current levels should donors withdraw (Office of the Prime Minister 2008). Finally, it was demonstrated again when certain donors decided to pull out of the health sector early on in the process without ascertaining the preferences of the host government. Subsequently, one senior official at the MoH expressed his extreme disappointment that the Irish Agency for International Development, which he described as "sincere," had pulled out of health, despite other "hypocritical" donor agencies opting to remain (MoH Interview 7th April 2008).

Indeed, the *Paris Implementation Report* has suggested that the DoL in Uganda has proven be a "divisive process" (Office of the Prime Minister 2008: 34) - presumably because it is so antithetical to donor agencies need to be in control. Subsequently, the *Report* suggests it will require staff across the board to develop new skills in facilitating and negotiation to see it through to completion.

I highlighted earlier the foresight of the BTC health team for having partnered a diplomat with a technical expert and also noted the disappointment of one donor

representative that such a large percentage of her work seemed to have little connection to what she termed the “field.” In consideration of these and the *Paris Implementation Report* recommendation to develop the negotiation skills of country staff, I will now address the final means through which the health development partners attempt to overcome their differences on the ground: through personal relations or, to put it another way, by virtue of the individual personalities currently participating in central sector processes.

The importance of individual personality at the country level in aid relations cannot be underplayed. As Walt *et al.* found:

“There is a fundamental, ongoing tension between the formal mechanisms established to coordinate aid, and the acknowledged importance of informal communications and relationships between different actors, in making coordination and management work” (Walt *et al.* 1999b: 278).

This explains the pressure that one new donor representative felt when she was first introduced to the multitude of coordination processes and groups inherent to Uganda’s health sector. She told me she was confronted by “all these donors that you have to liase with and get to know and get relationships with, and you’re not really comfortable... Who should you actually team up with and why and how?” (SIDA Interview 22nd May 2008). Indeed it was the same interviewee who underlined the importance of break times during some of the longer sector forums such as the Health Policy Advisory Committee, during which partners are able to approach each other informally to “lobby” for their own priorities and interests. And this lobbying was something I witnessed myself during the course of the fieldwork at large sector-wide forums such as the Joint Review Mission and the Mid-Term Review, where partners were to be seen approaching one other during panel presentations to hold private discussions, and conducting a bit of more overt networking during the coffee breaks. The issue of personality may also shed light on some of the behaviours the donors have been found to demonstrate on the ground. Hence why the DFID representative is engaged in so many extra-curricular activities in addition to managing the country health programme, or why the BTC Chair of the HDP Group

may perhaps have a more developed penchant for rules and procedures than some of the other HDPs.¹⁰⁰

In short, I hold with the position that “people matter” (Walt *et al.* 1999b: 274) when it comes to discussing organisational commitments to a coordination ethos, and when it comes to glossing over the differences that could make partnership at the level of Uganda’s health sector appear at first sight untenable. And while the following statement relates specifically to the “tyranny” of participation (Cooke and Kothari 2001), I think it holds true for all development endeavours, “we have possibly overlooked the significance of such highly personal criteria as respect, trust and even friendship in determining the success of many development projects” (Hailey 2001: 88). I would suggest therefore that the majority of donor representatives engaged in Uganda’s health sector at the field level are indeed committed to attaining the most meaningful engagement they can with their peers; yet that this commitment has to be viewed through the prism imposed by a multitude of inter dependant factors, over which those field staff have little or no control to change. Thus that a convincing semblance of coordination is currently being maintained within the sector forums is testament to the hard work of these individuals. It is important to attribute this feat to them personally – both within the HDPs Group and across government – because as Walt *et al.* warn, the success of coordination activities is contextually fragile “as contexts change, coordination which may be effective in one period, may not be in another” (Walt *et al.* 1999b: 274). Indeed, the challenges posed by such intransigence are well encapsulated in the following statement by a donor representative, who stands out in the HDP grouping for having spent ten years in her current position:

“Coordination - and like the way we’ve seen it in Uganda - is very people intensive. You need to keep at it and keep moving in a certain direction, so you need for people to feel that and to keep that vision going. And it’s not

¹⁰⁰ To introduce an example of the importance of personality to development from outside the donor sample, my fieldwork with WHO revealed that the politically neutral CSO Médecins Sans Frontières (MSF) had been convinced to partake in the UN Cluster for Health, HIV/AIDS and Nutrition in Uganda as an observer, despite MSF’s international stance damning the Cluster for contributing to: “The increasing politicisation of humanitarian action.” (Dubuet & Tronc 2006) I would suggest that this has been facilitated by the then-Health Cluster Chairman, who was himself an MSF employee in the past, and who maintained good relations with all the MSF sections in Uganda.

easy with quite high [staff] turnover...both in the Ministry and also on the donor side...It's not always possible to depend on what's written down... 'cause even what was written down – quite often things are behind what was written down – and so nowadays you go to a meeting and you see people questioning – not that they shouldn't question – but you know, lacking the basic understanding ...and then you realise that's part of the problem: [new people] not really knowing that we agreed to do this because of a, b and c. There are very good reasons why we agreed to do this. It wasn't a whim..." (Danida/MoH Interview 9th May 2008; also see Oliveira-Cruz *et al.* 2006).¹⁰¹

Viewed in this light, not only is coordination hard and at times frustrating work, it is also an invaluable exercise to try and instil some historical memory into the development process (countering the “historical amnesia” proposed by Easterly (2002: 49)).

In this section, I have suggested that despite the numerous obstacles to coordinated action even between an outwardly homogeneous grouping – that of Uganda's aid givers – the semblance of partnership can be achieved through several means: by keeping relations on a largely superficial footing, through a set of shared - yet inconsequential - bureaucratic devices, and through the subjective will of the personalities found within the sector at any one time. Moreover, that there are distinct advantages in pursuing even the most ‘pick and mix’ adherence to the coordination ethos: strength in numbers, donor bridging loans and the ability to share in sector-wide health successes. Finally, it has been suggested that, in accordance with the Paris Implementation Report, carefully designed incentives might facilitate greater compliance with aid effectiveness rhetoric in the field, even in lieu of what donors agencies would never submit to - punitive measures.

¹⁰¹ Commenting on Uganda's health SWAp, Oliveira Cruz *et al.* noted that “Uganda has so far benefited from a remarkable mix of individuals on the government as well as on the Development Partners side, who have shown strong character, leadership skills, vision, commitment and reform spirit as well as operational abilities to transform vision into practical steps. But individuals come and go. Hence the replacement of individuals in the MoH or the DP [Development Partners] groups may threaten the SWAp partnership if newcomers do not understand the essence of it, are not committed, or are too familiar and perhaps attached to the incentive structure of the project mode of funding” (Oliveira Cruz *et al.* 2006: 37-38). Such reasoning provides the backdrop to this comment, found in Danida's strategic plan for Uganda's health sector “a concern had been expressed...that with the departure of most of the original members of the partnership (on the government and HDP sides), the commitment to some of the SWAp principles is less clear than it was in the past” (Danida 2005).

Conclusion

The process of developing the UJAS in Uganda offered the first indication that reaching consensus between the HDPs wouldn't prove to be an easy task (and that process boasted a set of donors already united by their commitment to aid effectiveness). If you now factor in the complexities of involving a donor like USAID (whose field staff are heavily dictated to by the decisions of Congress) and/or the new Global Health Initiatives, one can begin to appreciate the magnitude of operationalising meaningful coordination measures at the country level in Uganda, even within the seemingly homogenous donor grouping. To then factor in the need to coordinate with obviously heterogeneous parties – government, civil society, the private sector – and the scale of the task can begin to appear untenable. Yet rather than suggesting that the coordination ethos is doomed to failure in Uganda, the HDP case study has affirmed that a 'pick and mix' version of the ideal is better than nothing. More than that, it boasts distinct advantages. Hence why both the HDPs and the GoU continue to strive toward an inconsistent adherence to the 'Partnership Principles' and attach different weightings to the tenets of Paris without rejecting the ethos in its entirety. The finding that aid donors and recipients may choose to pursue a development concept on a pick and mix basis, and in ways that serves their own ends is hardly a surprising finding of this thesis. It is a finding nonetheless and one which resonates with similar arguments already made by Sachs (1993), Crewe and Harrison (1998) Riddell (2007), Cooke and Kothari (2001), Mosse (2005) etc.

Crewe and Harrison (1998) have long belied the superpowers of donors. More significantly however, they made the connection that the Achilles heel of donors resides in their propensity (or lack thereof) for coordination:

“Donors are sometimes portrayed as strategically wielding the control they have over recipients for their own ends in a coordinated way to uphold the present capitalist system...[Yet] often donor interventions are neither strategic nor for their own ends because frequently, in practice, abuse of power is overshadowed in importance by a lack of coordination between donors” (Crewe and Harrison 1998: 89).

Thus, the HDP's faithfulness to a partial version of the coordination ethos in Uganda can be understood at once in terms of a genuine if not slightly pragmatic commitment to the tenets of aid effectiveness but also and more importantly, in terms of power. The act of creating a façade of unity - of homogeneity - vis à vis a domineering host government is an exercise - an exertion - of power, and it's vital if the donors are going to prevent the government employing divide and rule tactics. This was the conclusion I arrived at while watching the HDP Chairman deliver the shared donor statement at the Mid-Term Review of the Health Sector Strategic Plan in May 2008, in which the HDPs warned the MoH saying they wouldn't tolerate "business as usual."¹⁰² Moreover, it was reaffirmed for me in February 2010 when I learnt that Uganda's Development Partners Group had delivered a common statement threatening to withdraw development aid from Uganda en masse, realising the GoU's worst fear that budget support could be used as a 'stick' to beat it with over governance disputes (Observer Media Ltd 2010).¹⁰³ In both instances, the donors employed the device of speaking with "one voice," when addressing the GoU, attesting that coordinated donors can issue *coordinated* threats, even when their own commitment of the coordination ethos remains resolutely 'pick and mix'.

¹⁰² Quote from the Health Development Partners Group Statement, delivered on the closing day of the MTR of HSSP II, delivered on 29th May 2008.

¹⁰³ To underline the scale of the threat now in place and its connection to the coordination ethos, it is significantly donors under the Joint Budget Support Framework that are behind the threat aimed at the GoU in February 2010. Joint budget support wasn't in place at the time of the fieldwork but it was on the table. On my return from fieldwork therefore I asked DFID's UK office to explain the terminology and received the following explanation: "[Joint budget support] simply means that all general and some sector budget support decisions are linked to a joint assessment framework. That is, we work with the Government to agree on a set of performance indicators. Each year we assess progress against these performance indicators and produce a joint assessment report. Each budget support partner uses this assessment to make their individual budget support decisions" (Freedom of Information response from DFID, received 18th December 2008). It should be noted that about one third of Uganda's donors were not yet signed up for Joint Budget Support Framework by 2008 (Office of the Prime Minister 2008: 67). See Chapter Two for more details on the February 2010 donor statement.

CHAPTER FIVE:

COORDINATION TO MEET THE CURRENT DEMANDS OF CONTRARY AND RISK AVERSE GLOBAL FUND

Introduction

Time and again this thesis refers to the “unintended” (Ferguson 1990: 21), “instrument-effects” (Ferguson 1990: 256 citing Foucault 1979) and/or “unexpected consequences” of new aid initiatives (Walt *et al.* 1999: 279), suggesting that their existence owes much to the ideological (rather than empirical) underpinnings of the aid effectiveness agenda and the inherently “experimental nature” of official development assistance (Riddell 2007: 178). In this chapter the argument is made more explicitly as the focus shifts to the Global Health Initiatives (GHIs), which again share a common intuitive – rather than proven – appeal; namely that vast sums of money, concentrated on single-issue health interventions can reap rapid results for the global good.

Even a cursory look at the GHIs warns that there is no tested formula at work here - different funding models, guiding principles and management styles attest that the eighty plus GHIs to have emerged in the new millennium (WHO 2008: 2) are operating without an instruction manual. The situation is such that the three largest GHIs currently operating in the field of HIV/AIDS – the President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) and the World Bank’s Multi-Country HIV/AIDS Programme for Africa (MAP) – have been accused of undertaking a “large scale experiment” (Oomman *et al.* 2007: 3). The GHIs therefore provide the perfect medium with which to explore a further unforeseen by-product of the coordination ethos: coordination as a precondition for GHI funding success. Or to be more specific, coordination as the *current* precondition for funding success in GFATM applications,

because, as I shall demonstrate, the GFATM has with some regularity changed its mind about what it requires from a successful applicant.

In the introduction to this thesis I acknowledged the complexity that characterises the modern aid agenda. Such complexity is well evoked by the new GHIs, and in particular the Global Fund – which has greatly expanded the vocabulary of development specialists to reflect its peculiar working model. To provide a brief introduction, established in 2002 the Global Fund is a public-private partnership (incorporating governments, civil society, the private sector and infected communities) which works to attract and distribute new funding for the ‘big three’ infectious diseases thought to be placing an undue burden on developing health systems: HIV/AIDS, tuberculosis and malaria. Offering a new funding channel for existing bilateral and multilateral donors (as well as new benefactors), since its creation the Fund has grown to:

“become the main source of finance for programs to fight AIDS, tuberculosis and malaria, with approved funding of US\$ 19.3 billion for more than 572 programs in 144 countries. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria.”¹⁰⁴

Knowing something of the scale of the GFATM should tell you something of the current importance of the Fund to applicant countries in terms of global health funding – particularly in the fields of tuberculosis and malaria. Yet in order to glean something of how the Fund’s existence impacts on the day-to-day working life of its country partners (beyond scaling up aid for the ‘big three’) it helps to know a little about the GFATM operating model. The first thing to note is that the GFATM is not an implementing agency – it is conceived of as a financial instrument, designed to mobilise and distribute funds. And while this description evokes an image of relative simplicity, the scale of the resources currently on offer and the ideology of the Fund, which values the participation of multiple stakeholders in reflection of its own heritage of public-private partnership, have over time resulted in recipient countries having to develop supportive infrastructure to attract and manage GFATM grants.

¹⁰⁴ <http://www.theglobalfund.org/en/about/> [Accessed 30/09/10]

Boxes 8 and 9 are included to provide an overview of some of the key structures and processes involved in grant management at the country level. From a research point of view what is remarkable - given the complexity of the current GFATM *modus operandi* - is how well internalised the key concepts and processes are among the salient stakeholders at the field level.

Turning now to the case study, a handful of GHIs now operate in Uganda's health sector: the GFATM, PEPFAR, the President's Malaria Initiative (PMI) and the Global Alliance for Vaccines and Immunisation (GAVI). Of these, it is the GFATM that has, and continues to pose the greatest test to the coordination architecture at the country level. In part, this is as a logical consequence of its conceptualisation as a financial instrument as opposed to an implementing agency, which has meant it: "aims to operate within a broader network of partners, whereby its funding is complemented by the activities, expertise and resources of other agencies, national governments, NGOs, civil society organizations, and private sector partners" (Oomman 2007: 31). This was the model clearly established for it in the GFATM's 2002 *Framework Document*, which boasted of "a simplified, rapid, innovative process with efficient and effective disbursement mechanisms, minimizing transaction costs," that would support national strategies (including Sector-Wide Approaches) and give "due priority to the most affected countries and communities..." (GFATM 2002: 2-3). Yet as time has moved on, it appears that the reality of implementing the untested financial instrument has failed to live up to the hype, with an evaluation of its first five years of operation warning that the "bubble of unrealistic expectations" (GFATM 2009: 7) which accompanied its creation could yet be its undoing.¹⁰⁵

In this chapter I examine how the Fund's ideal to have a simplified and rapid disbursement process has played out at the country level in Uganda, arguing that a lack of clarity emanating from the GFATM Board with regard to partner responsibilities and funding guidelines has placed more demands on partners than at

¹⁰⁵ The evaluation identifies an array of financial, organisational, operational and political risks threatening the sustainability of the Fund, including most saliently to this discussion "A loss of partner and donor confidence..." (Macro International 2009: 46).

first envisaged and earned it the moniker of “\$60 million worth of nuisance” in some Ugandan circles (MoH/Danida Interview 9th May 2008).¹⁰⁶ In doing so I forward the proposition that ‘coordination’ is necessary to meet the *current* demands of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), helping it justify the continuation of grants to Uganda following the 2005 mismanagement scandal. Subsequently, while the Fund would couch the impetus for Uganda to demonstrate broad stakeholder consultation in the application and grant management process in terms of creating a participatory, needs-based proposal, and improving the utilisation and impact of grants, my argument is that the processes and mechanisms of participation/coordination also serve to allay some of the risk incurred in providing aid to Uganda by increasing the number of stakeholders involved in grant oversight. And while such a set up isn’t in and of itself overtly problematic – given that it is in the interest of all Uganda’s stakeholders (in their respective roles as GFATM contributors and beneficiaries) to maintain the flow of Global Fund monies to Uganda – the costs incurred in allaying the Fund’s concerns have escalated in recent years in response to the GFATM’s own uncertain strategic development. This I argue is because the Global Fund is as suggested, a large-scale experiment, where all partners at the country and global level are embroiled on a steep and costly “learning curve” (Donoghue et al. 2005: 10).¹⁰⁷

¹⁰⁶ An interviewee told me about a scene she witnessed at a conference where someone vocalised their exasperation with the GFATM, saying ‘You know it actually comes across as a nuisance.’ A GFATM representative at the conference was annoyed at this suggestion, retorting “\$60 million of nuisance?” (which was approximately how much Uganda had been approved to receive that year). The Interviewee explained that now several people weighed in: “We said: ‘Yes that’s what it is.’ Because it could do a lot, lot, lot, lot more than it is currently” (Danida/MoH Interview 9th May 2008).

¹⁰⁷ A tracking study covering the early years of the GFATM’s operation in Uganda noted that “everyone was on a learning curve, including the Global Fund...” (Donoghue *et al.* 2005: 10).

Box 8: Global Fund Structures

A. At the central level:

The **Global Fund Secretariat** manages the grant portfolio, including screening proposals submitted, issuing instructions to disburse money to grant recipients and implementing performance-based funding of grants. More generally, the Secretariat is tasked with executing Board policies; resource mobilization; providing strategic, policy, financial, legal and administrative support; and overseeing monitoring and evaluation. It is based in Geneva and has no staff located outside its headquarters.

The **Technical Review Panel (TRP)** is an independent group of international experts in the three diseases and cross-cutting issues such as health systems. It meets regularly to review proposals based on technical criteria and provide funding recommendations to the Board.

The **Global Fund Board** is composed of representatives from donor and recipient governments, civil society, the private sector, private foundations, and communities living with and affected by the diseases. The Board is responsible for the organization's governance, including establishing strategies and policies, making funding decisions and setting budgets. The Board also works to advocate and mobilize resources for the organization.

B. In the recipient country:

The **Country Coordinating Mechanism (CCM)** is a partnership composed of all key stakeholders in a country's response to the three diseases. The CCM does not handle Global Fund financing itself, but is responsible for submitting proposals to the Global Fund, nominating the entities accountable for administering the funding, and overseeing grant implementation. The CCM should preferably be an already-existing body, but a country can instead decide to create a new entity to serve as CCM.

In Uganda, the CCM is composed of two existing bodies: the Health Policy Advisory Committee and the Partnership Committee of Uganda AIDS Commission

The Global Fund signs a legal grant agreement with a **Principal Recipient (PR)**, which is designated by the CCM. The PR receives Global Fund financing directly, and then uses it to implement prevention, care and treatment programs or passes it on to other organizations (**sub-recipients**) who provide those services. Many PRs both implement and make sub-grants. There can be multiple PRs in one country. The PR also makes regular requests for additional disbursements from the Global Fund based on demonstrated progress towards the intended results.

The Ministry of Finance, Planning and Economic Development has been appointed as the sole Principal Recipient in Uganda

Since the Global Fund does not have staff at country level, it contracts firms to act as **Local Fund Agents (LFAs)** to monitor implementation. LFAs are responsible for providing recommendations to the Secretariat on the capacity of the entities chosen to manage Global Fund financing and on the soundness of regular requests for the disbursement of funds and result reports submitted by PRs.

International Accounting Firm PriceWaterHouseCoopers is the Local Fund Agent for Uganda

Adapted from GFATM website: <http://www.theglobalfund.org/en/structures/> [Accessed 30/09/10]

Box 9: Global Fund Processes

A. Round Funding



As the diagram to the left outlines, the GFATM board is charged with issuing calls for proposals. Until recently, these calls for proposals have been made exclusively via a **Round** system. Since the Fund's creation in 2002, ten rounds have been advertised, each with their own specific guidelines.

In country, the members of the CCM are charged with **developing country proposals**. It is the decision of this coalition of stakeholders whether or not to submit an application in a given funding round and if so, whether the country will submit a proposal for one, two or all three of the disease components (i.e. HIV/AIDS, tuberculosis and malaria). Proposals are detailed affairs and in addition to requesting a specific amount of funding, applicant countries must account for how they would utilise an awarded grant.

Submitted country **proposals are subject to review** by the Technical Review Panel, which can either choose to accept or refuse proposals outright, or advise applicant countries of potential changes they might make to render the application successful.

The GFATM board approves grants based on technical merit and the availability of funds. **Applicants are informed of whether or not they have been successful** and if so, how much money has been awarded in principle.

Before signing off on the grant, countries must **meet a list of conditions precedent (CPs)** determined by the GFATM. These conditions for receiving the funds will be peculiar to the funding round and the applicant country. It may take many months for the country to meet every CP. Once these are met, the GFATM and the country will proceed to grant signing.

Following grant signing, the first two-year instalment of the GFATM grant will be issued to the designated Principal Recipient in country. As the GFATM is a performance-based funding initiative, the release of subsequent funding tranches is dependent on the country's performance in using the first instalment.

B. National Strategy Applications

In 2008, the GFATM approved the launch of the pilot of a new application procedure, called **National Strategy Applications (NSA)**. This simplified application route is intended to negate the need for countries to develop individual, round-specific applications. Instead, eligible countries submit existing national disease strategies as the primary basis of their application (although some supplementary information is also required).

Source of diagram: <http://www.theglobalfund.org/en/structures/> [Accessed 30/09/10]

The Donor Perspective

Although extremely difficult to quantify in terms of a quotable figure, the fact of the matter is that coordination between the various stakeholders in Uganda's health sector *costs* - not just in terms of money but also in terms of time expended (i.e. the opportunity costs). While the idea of burdensome transaction costs to the recipient country is well documented in aid discourse, for the purpose of this introduction it is easier to exemplify the full range of costs incurred by the GFATM at the country level from the perspective of the Development Partners, who in Uganda's health sector have traditionally covered the financial and thus - pre-GFATM at least - predominantly administrative costs of partnership. Consider therefore the following hypothesised scenario, which attempts (if a little crudely) to condense the issues involved in managing the GFATM partnership from this vantage point.

You work for a donor organisation based in Uganda, a country that has met your government's criteria to receive foreign aid. In keeping with both the spirit of Uganda's sector-wide approach (SWAp) in the health sector and the principles underpinning the Paris Declaration, your organisation is an active member of the coordination forums that guide actors in the health sector. In this role you will have likely participated in health policy discussion at the Health Policy Advisory Committee (HPAC) and perhaps even helped to develop strategic plans for the sector in the Technical Working Groups (TWGs). Your national government has made a substantial donation to the GFATM in the belief that its comparative advantages made it the perfect mechanism through which to scale up the global response to AIDS, tuberculosis and malaria. From your vantage point it seems obvious that the GFATM should be supporting national efforts to combat the 'big three' in Uganda but there's a complication: in order for your host country to have any chance of receiving GFATM funding your donor organisation at the country level is being asked to dip its hand into the pot a second time to fund the convoluted application process that has become a key feature of the GFATM. This is to help fund external consultants and a lengthy participatory exercise to ensure that all stakeholder voices

are adequately represented in the proposal.¹⁰⁸ You could attempt to bypass one or other of these extremely costly variables but then you could be fairly certain that the country's application would be unsuccessful. Moreover, in the event that the proposal is approved, you should be prepared to pay out a third time in Uganda because it is now agreed that the implementation of the GFATM grants needs to be supported with partner-funded long-term technical assistance (TA). The onus therefore is on you and your in-country partners to "make the money work" (GTT 2005).¹⁰⁹ And just in case you were wondering, you can't make an advance claim for TA as part of the GFATM application - or can you? Quite frankly no one is very clear on what exactly you can and cannot apply for - the GFATM Secretariat is not always good at issuing guidance – meaning that the only thing you and your partners really know for sure is that you can't afford to make any mistakes.¹¹⁰ In short, your mantra with regards to the GFATM at the country-level needs to be 'speculate to accumulate', and this alludes to both your time and your money, because lest we forget the monthly coordination forum you have regularly attended in the health sector has recently been designated as the new Country Coordinating Mechanism (CCM) for the GFATM.

Turning now to the response of a real-life Development Partner to this set up, it becomes clear that this wasn't the working relationship envisaged by contributing partners at the time of the GFATM's inception:

¹⁰⁸ The central role of outsourced technical assistance in securing GFATM grants is evidenced in the Fund's endorsement of Avrett, S. & Rivers, B. 2004. *The Aidspan Guide to Obtaining Global Fund-Related Technical Assistance*. It terms this "a valuable source of information, which includes a list of organisational and individual providers" (GFATM 2006: 21).

¹⁰⁹ In 2005 the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors produced a report making recommendations on how to increase the effectiveness of HIV/AIDS funding, including through the strategic use of donor-funded technical assistance. This was a follow up to a multi-stakeholder consultation held on 9th March 2005 entitled: "Making the Money Work: The Three Ones in Action."

¹¹⁰ The GFATM application guidelines suggest that following review by the TRP, proposals are graded in four categories to be submitted for Global Fund Board approval: Category 1 - recommended for approval without changes; Category 2 - recommended for approval with minor changes; Category 3 - not recommended in its current form, but strongly encouraged to re-submit following major revision; and Category 4 - rejected. <http://www.theglobalfund.org/en/rounds/applicationprocess/> [Accessed 20/01/09]. However, a review of the GFATM review process in 2006 suggests that "Under the present guidelines, the TRP recommends either accepting or rejecting a proposal in its entirety." This it points out risks "screening out 'innovative' approaches..." (GFATM 2006: 12).

“Everything right now [in Uganda] seems to centre on the Global Fund. It’s just driving me crazy... And now HPAC [Health Policy Advisory Committee] and PC [Partnership Committee of the HIV/AIDS Partnership] are somehow joined together as CCM and as much as I see that as being extremely relevant because they do touch it also means everything focuses on Global Fund. And to me it’s just a financing mechanism. It’s a shame the Ministry [of Health] has to dedicate so much time to it. At the same time they don’t want to do it so that hire eight *really* expensive consultants to write the proposal. But that’s not right either... And we’re big donors to the Global Fund but I’ve also talked to our Swedish Board members about this and they’ve taken note. They said it shouldn’t be like this. It shouldn’t be that AIDS Commissions and CCMs recruit eight external consultants to do proposals. And then they ask the same donors that are putting money into the Global Fund to fund those consultants. It’s sick. They were shocked when I told them but that’s the way it is” (SIDA Interview 22nd May 2008).

Shakow has likened the escalating costs incurred by in-country partners through their involvement with the GFATM to the economic problem of the “free rider.” In sum, the envisioned light touch of the GFATM (in particular its determination to have no country presence) has led to:

“an increased demand on the staff of other organizations to do the Global Fund’s in-country project development, proposal writing and follow-up work... It has also created in other organizations, especially WHO, a direct financial burden for unfunded services...” (Shakow 2006: 21).

I shall return to notion of “unfunded mandates” (GTT 2005: 15) and the escalating costs of managing the GFATM through the partnership model at the country level in Uganda in due course. First however, it is insightful to see where the GFATM ideal may have gone awry at source – at the level of the GFATM architecture.

The Reactive Evolution of the GFATM

At some level all GHIs are conceptualised as an alternative to ‘business as usual’ in the provision of development aid.¹¹¹ For the GFATM founders, this stance was

¹¹¹ Rogerson *et al.* (2004) view vertical health initiatives such as the Global Fund to Fight AIDS, TB and Malaria as “a response to the perceived failures of ‘big aid’” (Rogerson, Hewitt & Waldenberg 2004: 20). Guided by the principal of additionality and the need to cut down on the bureaucratic

perhaps most keenly reflected in the early years in its strong statements about what it would *not* do, as opposed to how, beyond simply mobilising and distributing funding, the GFATM would rally its partners to “make the money work” (GTT 2005). What was stated explicitly was that it wouldn’t mirror the traditional donor *modus operandi*. It wouldn’t waste valuable resources or challenge national sovereignty by maintaining a country presence. It wouldn’t burden countries with high transaction costs or slow disbursement processes. And it wouldn’t politicise aid, allocating instead according to the greatest need and adamant that the format of the country proposal “should not be overly elaborate and not impose undue burden on the countries” (GFATM 2002: 7). The virulence of this reactionary stance has subsequently been picked up in several studies, whereby the determination of the GFATM architects to set themselves apart from “old, established agencies” (Shakow 2006: 43) has been blamed for creating tensions with their counterparts at the World Bank and UN agencies.¹¹² This position now appears somewhat shortsighted given that the centrepiece of the GFATM vision is the partnership model, which necessitates the support of all partners.¹¹³

The recent *Five-Year Evaluation of the GFATM* concluded that in its first five years of operation the GFATM lacked an overarching strategic vision, subsequently “the

demands of traditional aid modalities, they underscore how such approaches aim to mobilise and disburse resources quickly in order to tackle emerging global health threats. The GFATM has attracted praise from the Commission on Macroeconomics and Health, which acknowledged that scaled-up health funding required “a new *modus operandi*” (Commission on Macroeconomics and Health 2001: 13). That said, the additionality of GHI funding is extremely hard to prove and the evidence base is mixed. Lief *et al.* (2006) have argued that increased spending on HIV and AIDS has not come at the expense of funding for other areas, while Shiffman (2008) has suggested that donor prioritisation of HIV/AIDS is likely to have caused some displacement, although aggregate increases in global health aid may have mitigated some of the crowding-out effects. Nabyonga *et al.* (2009) suggest that an agreed approach to measuring the additionality of donor aid would be useful in Uganda.

¹¹² The *Five-Year Evaluation of the GFATM* commented on the “persistent efforts of the Global Fund to distance itself from more explicit partnerships with the three institutional members of its Board (WHO, the World Bank, and UNAIDS) during the evaluation period” (Macro International 2009: 55). It also noted that “We are not the UN” was among the most frequently made statements concerning GFATM identity made by board members in interviews undertaken for the evaluation (Macro International 2009: 36).

¹¹³ The *GFATM Framework Document* states: “The Fund will promote partnerships among relevant players within the existing country, and across all sectors of society. It will build on existing coordination mechanisms, and promote new and innovative partnerships where none existed” (GFATM 2002: 5). The mechanism devised to operationalise this ideal at the country level is the Country Coordination Mechanism.

ad hoc growth and reactive evolution of the Global Fund architecture has brought with it increased procedural complexities and a spate of policy that have led to confusion, and in some cases, contradictions” (Macro International 2009: 54). It notes that the governance structures of the Fund have developed slowly and its policy incrementally – so less strategically than was needed to cement a partnership model. As it stands, collaborating organisations are left to “‘wait and see’ where the Fund is going,” unable to adequately plan their own strategic interventions. More worrying, many of the issues the GFATM board are found to be debating five years into operation are so fundamental that decisions taken in a particular direction could render the Fund unrecognisable. Case in point, the *Evaluation*’s comment that “The board has thus far not dispelled that uncertainty with respect to its intention to remain a ‘financing instrument only’ institution, or seek to broaden its functionality” (Macro International 2009: 55).

The GFATM has been undergoing a strategy review since 2006, which appears to be an inordinate amount of time for such a young initiative and begs the question: why has it found it so difficult to reach decisions?¹¹⁴ A telling finding therefore - given the theme of this thesis - is that the sheer breadth of stakeholder participation and the high representation of special interest constituencies on the GFATM Board has made consensus very hard to achieve and meant that broad policy issues are rarely at the heart of its agenda (Shakow 2006).¹¹⁵ Of the issues on which the Board continues to demonstrate a lack of clarity, three have direct bearing on the role of partners at the country level. These concern: the respective responsibilities of partners, the funding of technical assistance and the correct role of the GFATM in funding health system strengthening.¹¹⁶

¹¹⁴ Alluded to in PEPFAR, World Bank & GFATM 2006: 11

¹¹⁵ The GFATM board is made up of multiple constituencies, including a high percentage of civil society representatives. Chapter Seven establishes how the Fund has attempted to mandate this model be emulated in Country Coordinating Mechanism at the recipient country level.

¹¹⁶ Please note in addition to the issues raised in this discussion, the GFATM is also debating whether or not to continue round-based funding (PEPFAR, World Bank & GFATM 2006). Furthermore, the *Five-Year Evaluation* hints that the GFATM may not be entirely averse to the idea of establishing a country presence should the need arise. The *Evaluation* recommends that in order to ensure in country representation of the Fund and functional partnership at the country level the GFATM should consider placing its own staff on CCMs, although only as a “as a last resort” (Macro International 2009: 39).

An assessment carried out by the GFATM in 2006 found that persistent misconceptions about the Fund's principles at the country level demonstrated the "inability of the Fund to effectively mobilise its bilateral and multilateral partners, who have a country office and who could correct such misconceptions" (GFATM 2006: 23). At this point an ineffective communication strategy was blamed for the communication breakdown at the country level. By 2009, the poor quality of the relationship between the GFATM and its partners is depicted in a more serious light as the *Five-Year Evaluation* finds that "The Global Fund's approach during its first five years reflects a "friendship model' rather than a genuine 'partnership model'" (Macro International 2009: 34).¹¹⁷ It goes on to say that the approach has been undermined by a lack of clarity concerning the roles and responsibilities of individual partners and a failure to establish effective collaboration between them. The unclear division of labour is found to be particularly detrimental at the country level where widespread confusion over respective roles was identified within CCMs and between GFATM entities such as CCMs, Local Fund Agents, Principal Recipients and Sub-Recipients. Moreover, an ongoing dispute between the GFATM and Development Partners at the country and global level over the interpretation of the following passage of the GFATM *Framework Document* threatens to turn ugly: "Technical support for preparing proposals and developing country level partnership could be provided for by partners active in the country, such as bilateral donors and UN organizations" (GFATM 2002: 12). A textbook case of slippery wording, the 2009 *Evaluation* warns that: "This lack of clarity...is contributing to a perceived problem of 'unfunded mandates' among technical partners who have much to do to systematically mobilize themselves to provide technical assistance to Global Fund grants" (Macro International 2009: 37).

Indeed the issue of who should fund technical assistance (TA) has become a hot potato for the GFATM and one that threatens to alienate donors. The issue has been compounded by the reactive, rather than strategic development of the Fund, which had failed to anticipate the scale or complexity of TA that would be required by recipient countries for grant implementation. Whereas TA was originally judged

¹¹⁷ Dr Ian Harper at the University of Edinburgh thinks a more apt description would be the "tyranny of financial determinism" (Discussion 28th January 2010).

necessary for putting together country proposals and facilitating partnership fora, it is now widely recognised as integral to the success of GFATM – and other GHI - funding (Sidibe *et al.* 2006). The ongoing debate is quite simply over who should pay - a fundamental distinction the GFATM neglected to pin down at its inception (the *Five-Year Evaluation* alludes to a persistent belief within the Fund of the ‘trickle down’ effects of aid).¹¹⁸ The upshot, as both the 2009 *Evaluation* and this Uganda study attest, is that many partners feel they have already paid up front for TA in their contribution to the Fund and should not be asked again.

Another issue over which the GFATM has been slow to take a definitive standpoint regards Health Systems Strengthening (HSS).¹¹⁹ Again the debate has been confused by the ambiguous wording of the original *Framework Document* and now centres on a question of comparative advantage; in short, is HSS something the GFATM is suited to funding?¹²⁰ Certain features of the Fund’s modus operandi would suggest it is not. Firstly, two to five year grants would imply an inadequate timeframe to make lasting system changes. Secondly, it has been noted that the Technical Review Panel set up by the GFATM to review country proposals lacks the capacity to judge HSS applications, which would require a high level of up-to-date institutional and political knowledge.¹²¹ Finally, certain GFATM Board members have voiced their own concerns that a foray into HSS would signal a dilution of the Fund’s original mandate to focus on the ‘big three’ (Sidibe *et al.* 2006; Shakow 2006). In spite of such objections however, the GFATM has been incrementally developing a

¹¹⁸ The *Five-Year Evaluation* notes that while the GFATM was established with an expectation that partners would be proactive about addressing TA requirements, “the financing of technical assistance was not explicitly addressed except for the assumption that increases resources in-country would enable more ‘demand-driven’ international technical assistance – putting the onus for TA requests and financing on program countries” (Macro International 2009: 13).

¹¹⁹ The *Five-Year Evaluation* suggests that the GFATM was established “with the expectation that strengthened health systems would be an almost inevitable consequence of increased health sector spending...[HSS] was not a first order preoccupation at the time” (Macro International 2009: 11-12).

¹²⁰ The GFATM *Framework Document* states the Fund will support programs that “Address the three diseases in ways that will contribute to strengthening health systems” (GFATM 2002: 4). Yet Shakow 2006 and Sidibe *et al.* both question the suitability of the GFATM to involve itself directly in HSS. Shakow argues the GFATM should avoid making HSS into a separate priority category in Round 6 and future RFAs, explaining: “This does not mean that the Global Fund should be unconcerned with health system strengthening, but it should mean that the lead role in this area should generally be assigned, as a matter of policy, to the World Bank (Shakow 2006: 50).

¹²¹ The Technical Review Panel has raised its own concerns in this area, pointing out that “the GFATM system is currently not set up to generate strong Health Systems Strengthening proposals nor to evaluate these effectively” (GFATM 2005: 25).

specialisation in HSS since Round 5 when HSS was first introduced as a cross-cutting category. Since Round 7, the Fund has encouraged - and now requires - proposals to include an HSS cross-cutting component (Macro International 2009). Nevertheless, it is important to acknowledge the contextual background to this shift – because the GFATM does not operate in a vacuum – and the momentum to include an HSS component in health initiatives has been building at the international level for some time.¹²²

Ignoring the suitability or otherwise of the GFATM to fund HSS, for the purpose of this discussion it is more instructive at this point to mention that out of the thirty HSS applications submitted to the GFATM in Round 5, only three were approved by the Technical Review Panel. Shakow has explained the mass failure as follows: “guidelines were unclear, preparation time was short and few health systems programs exist in-country on which to build new proposals” (Shakow 2006: 27). In short, the majority of HSS applications submitted in Round 5 were deemed sub-standard by the Technical Review Panel. I would posit however, sub-standard according to what criteria? Without issuing clear guidelines as to what is expected from applicants, the GFATM opens its review processes up to accusations of arbitrariness. The Fund’s lack of preparation to either solicit or review proposals points again to the reactive policy making of the GFATM.

Taking these issues together it is clear that the lack of long-term strategic vision and slow pace of the GFATM Board’s decision making have become major stumbling blocks at the country level to funding success. So much so, that I would posit the uncertainty surrounding the Fund has added a new potential cost to multi-stakeholder coordination at the country level: the cost of failure. This is the cost incurred when countries, struggling to decipher the requirements of the GFATM from afar, invest in what ultimately become failed proposals. As the Ugandan case study will attest, a natural response for partners to such failure is to invest even more time and money (for instance contracting external expertise) when developing future proposals. The

¹²² For instance, the WHO supports a HSS approach <http://www.who.int/healthsystems/en/> [accessed 15/05/10], and the Stop TB Partnership has incorporated a HSS component into its global strategy (WHO 2006b).

idea that esoteric expertise should be required to access life-saving funding is without question an anathema to the original conceptualisation of the Fund. Moreover, the notion is rendered wholly problematic if you accept that the GFATM isn't always clear about what it's looking for.

The overriding message to emerge from the numerous critiques of the GFATM in recent years is that the Fund needs to offer clarification on a number of fundamental issues or risk its reputation with partners and donors. This, at its crux is a warning to the Fund's own sustainability (GFATM 2006; Shakow 2006; Sidibe *et al.* 2006; Macro International 2009).

The GFATM in Uganda

The Ugandan case study provides a wealth of material to demonstrate the impact of the GFATM's ambiguity at the country level. Most striking is that in the course of its seven years of operation the Fund has taken a u-turn in its policy toward Uganda. From turning down the country's integrated proposal in Round 1 - the Fund at this stage demanded that the disease components be separated and that the country set up a Project Management Unit (PMU) to manage the grants – the GFATM demanded an integrated proposal and endorsed the country's Long-Term Institutional Arrangements for managing the grants in Round 7.¹²³ In the midst of this u-turn there was of course the high-profile mismanagement of the GFATM grants in Uganda in 2005 and the Fund's subsequent three-month suspension - an incident after which the GFATM emerged looking rather well in international circles for demonstrating its punitive muscle (Shakow 2006; Sidibe 2006), but which left some in Uganda with a bad taste as the Project Management Unit the GFATM had insisted upon installing (and which sat, dislocated from the state apparatus) was found to have provided the perfect vehicle for the mismanagement.

¹²³ The overriding principle guiding of Uganda's Long-Term Institutional Arrangements is: "the realignment of all funding mechanisms to existing institutional arrangements..." (Doc 1. 2006: 5).

A high-level Ministry of Health official expanded on the previous arrangements governing the GFATM funds in Uganda. He told me the PMU had been forced on Uganda and had caused a lot of confusion. With it there had been no alignment with the government, no proper supervision and a lack of direction. He also pointed out that the PMU had led to a lot of duplication (MoH Interview 7th April 2008). His account recalls some of the original concerns voiced about the PMU in an earlier study:

“The structure of the Global Fund fiduciary system in Uganda raised the question as to whether the CCM was adequately positioned to perform the oversight role envisaged for it by the Global Fund. The CCM was not part of the chain of information sharing, decision making and responsibility that linked the MoFPED (as the Principal Recipient) with the PMU, as the body responsible for day-to-day management of funded activities. Consequently many stakeholders shared concerns about matters of decision-making, transparency and accountability. Locating procurement under the PMU was also a cause of considerable disquiet among some CCM members” (Donoghue *et al.* 2005: 44).

Biesma *et al.* have also commented that the government of Uganda and its Development Partners regarded the PMU in 2003 “as a distortion of Uganda’s policy of channelling all funds to support a coordinated national health sector strategy” (Biesma *et al.* 2009: 242).

Such findings evoke the unequal relationship that still exists between aid recipients and their donors where the recipient country is powerless to overturn the donor’s prescriptions. That the GFATM – having been burnt in Uganda – has since rescinded both its decision to operate through a PMU and to insist upon a disaggregated proposal is again indicative of the Fund’s trial and error approach.

A second, less high-profile caveat to the Ugandan experience of the GFATM grant process is the country’s relatively poor success rate in winning funding: out of nine GFATM funding rounds to date, Uganda has only succeeded in three rounds for HIV/AIDS, three for malaria and two for tuberculosis (see box 10 below).¹²⁴

¹²⁴ <http://www.theglobalfund.org/programs/portfolio/?countryID=UGD&lang=en> [Accessed 24/11/09]. Even these statistics do not present the full picture of Uganda’s funding track record with

Box 10: Uganda's Record of GFATM Round Funding Success

GFATM ROUND	DISEASE PROPOSALS SUBMITTED	OUTCOME
1	HIV TB Malaria	Success Failure Failure
2	TB Malaria	Failure Success
3	HIV	Success
4	Malaria	Success
5	Malaria	Failure
6	TB Malaria	Success Failure
7	HIV TB Malaria	Success Failure Success
8	HIV TB Malaria	Country develops, but then fails to submit a proposal
9	HIV TB Malaria	Failure Failure Failure

Of course Uganda has not applied for funding in every round, but as an examination of Uganda's experience in recent funding rounds will reveal, this in itself says something about the increased bureaucratisation of the aid instrument. Furthermore, as even a quick glance at the table above would intimate, members of Uganda's Health and HIV/AIDS Partnerships have been expending energy in proposal development on an annual basis since the Fund's inception, regardless of outcome.

regards the GFATM however. Another statistic to consider is 'Grants in Progress'. This takes into account only those grants for which the country is enjoying disbursements in 2011. This sees Uganda receiving just five grants. To put this into context, in 2011 Rwanda is receiving seven grants and Kenya twelve. This reflects the finding presented later in this chapter that Uganda has had two grants discontinued since the 2005 mismanagement scandal. Of course both a notion of funding 'success' and the idea of comparing different country awards are problematic when you consider that the GFATM is not providing competitive funding. Rather the Fund was envisaged as a simple disbursement tool, disbursing grants according to a needs-based system.

<http://portfolio.theglobalfund.org/en/Country/Index/UGD> ;
<http://portfolio.theglobalfund.org/en/Country/Index/RWN>;
<http://portfolio.theglobalfund.org/en/Country/Index/KEN>
 [Accessed 18/07/11].

A third and related issue concerns the disbursement rate of the GFATM. In Uganda it appears that getting the money (after approval in principle) takes an inordinate amount of time. I shall touch on this issue later when addressing the inherent tension undermining the Fund's *raison d'être*: its current inability to manage risk.

The point I wish to make using the Ugandan case study is not simply that there are costs involved in operationalising the Fund's partnership model at the country level – that is a given. The point is that the costs have escalated beyond what was anticipated in the original conception of the Fund. It is these uncapped costs – incurred as a result of the shifting goalposts of the GFATM (and perhaps even its lack of country presence) - that the stakeholders involved in Uganda's Health and HIV/AIDS partnerships are now being asked to absorb.¹²⁵ The definitive example concerns the expense now involved in developing country proposals, which shall become the main focus of this discussion.¹²⁶

Producing a GFATM Proposal

The fieldwork that forms the basis of this thesis was carried out in 2007 and 2008 when Uganda was involved in funding Rounds 7 and 8 of the GFATM. I shall introduce the empirical data from this period forthwith. First however, it is helpful for the purpose of this discussion that the GFATM commissioned a country tracking study in 2005 (Donoghue *et al.* 2005), capturing the early years of the Fund's operation in Uganda. A significant finding of that study was that for GFATM funding Round 1, Uganda's Ministry of Health devised a cross-cutting proposal for the three diseases, reflecting the country's burgeoning health SWAp and its commitment to decentralisation in the sector.¹²⁷ The country and its Development

¹²⁵ In Uganda the AIDS partnership is separate although logically connected to the health SWAp. This is because the AIDS partnership represents Uganda's multi-sectoral response to HIV/AIDS. (See http://www.aidsuganda.org/npdf/overview_of_coordination.pdf [Accessed 10/03/10]). Whereas in other chapters I have focused predominantly on the Health Development Partners (HDPs) who support the SWAp, in this chapter I also discuss the AIDS Development Partners (ADPs), who provide financial and/or technical expertise to the AIDS Partnership in Uganda. In many instances there is overlap between the members of the HDPs and the ADPs (for instance DFID and SIDA are both health and HIV donors). But there are also examples of ADPs not attached to the health sector (for instance Irish Aid, which funds HIV/AIDS activities connected to the education sector).

¹²⁶ Please note that my fieldwork did not address the issue of managing, or assessing the performance of, GFATM grants in Uganda.

¹²⁷ Uganda's SWAp and decentralisation policy are discussed in more detail in Chapter Seven.

Partners were thus dismayed when the proposal was rejected by the Technical Review Panel, which asked that the proposal be redrafted and broken down into three component parts along disease lines. The amended version was submitted in the format requested. Nevertheless, only the HIV/AIDS component was successful.

Donoghue *et al.* have suggested that Uganda's experience with Round 1 had "quite a profound impact, which appeared to influence Uganda's subsequent approach to the Fund" (Donoghue *et al.* 2005: 9). In short, the government was left disillusioned with the GFATM, feeling that it didn't understand what Uganda was trying to achieve with its sector-wide approach in health.

While there was some improvement in what was perceived as the GFATM's sensitivity to country processes during Round 2, for Rounds 3 and 4 the Ministry of Health decided to outsource the proposal drafting to external consultants, reporting that "the Round 1 process had consumed too much time and energy of senior MoH staff" (Donoghue *et al.* 2005: 11). Moreover, it was noted that the proposal preparation guidelines, which had been considered as inadequate for Round 1, had become overly complicated by Round 3.

By Round 4 the process of developing the GFATM proposal was reported to have become better internalised in Uganda. Nevertheless Donoghue *et al.* reported that "Lack of certainty about the rules and requirements persisted into later rounds" (Donoghue *et al.* 2005: 12). Furthermore, the uncertainty noted in Uganda was found to be consistent with the experience of other countries, as the GFATM's *Assessment of the Proposal Development and Review Process* found in 2006, "The Assessment elicited a number of misconceptions at country level about the Global Fund principles, policies and procedures, which are negatively affecting the proposal development process" (GFATM 2006: 12).

By Round 5 it was remarked that despite conscious efforts to avoid excessive amounts of information being submitted in proposals (in an effort not to over burden the TRP), the level of detail required had in fact increased, as information on country

context and capacity became requisite inserts for the application. Moreover, it was warned that the volume of information would likely escalate again as data became more systematically available at the country level and countries began to comment on the performance of their previous grants (GFATM 2006). This development is verified in the Ugandan case material, where a WHO interviewee was heard to say:

“The Global Fund says they’re simplifying now but there are areas where you get repetition. You answer the question and then you go ahead and think ‘isn’t this the same question from before that they’re asking again?’ If you want the money you still have to answer it” (WHO Interview 22nd April 2008).

The same interviewee also highlighted the relative difficulty of amassing the requisite information in the context of a developing health system, saying: “it may be easy in your country but for us it is not so easy. It’s hard where to pick that data from” (WHO Interview 22nd April 2008).

In sum, early discourse on the GFATM points to two unplanned for deviations from the GFATM’s original pledge that the country proposal “should not be overly elaborate and not impose undue burden on the countries” (GFATM 2002: 7). Namely, the bureaucratisation of the Fund’s application procedure and the creation of a pseudo-profession, professional form-filling, carried out either by external consultants, the technical staff of in-country ministries/partner organisations or both. Both these phenomena are amply demonstrated in the Uganda case study with regards to Round 8, by which time it was found that the proposal guidelines had changed again making broad stakeholder consultation a further pre-condition for funding success.¹²⁸

GFATM Round 8

Toward the end of the fieldwork period in May 2008, the stakeholders in Uganda’s health SWAp and multi-sectoral HIV/AIDS partnership were found to be busily preparing the GFATM country proposal for Round 8. Indeed, this is the context of

¹²⁸ In Chapter Seven, I explore how the GFATM has over time tacitly mandated the inclusion of civil society and other NGO partners in CCMs. The representatives of these parties must solicit the views of their constituencies to feed into the proposals.

the sound bite near the start of this chapter, when the Health/AIDS Development Partner complained: “Everything right now seems to centre on the Global Fund. It’s just driving me crazy...” (SIDA Interview 22nd May 2008). Beyond mentioning that the MoH were now so fed up with the GFATM’s time-heavy bureaucratic processes that they have hired “eight *really* expensive consultants,” the same donor went on to attach a figure to the financial cost of Uganda’s Round 8 application.

“We got this budget yesterday for the Global Fund and for them to put this together...is going to cost – this is just for curiosity – Uganda Shillings 653 million.¹²⁹ This is including field consultations, and then of course you have full-board for 15 participants in all the districts, transport refund, DSA for the consultation team, DSA for the drive, airtime. And then you have like a writing retreat - full board in Jinja for writing and drafting things; and then you have the overall lead consultant” (Interview 22nd May 2008).¹³⁰

Moreover, a costly complication involving the hired consultants is acknowledged:

“Actually all these consultants are local because we asked [for that] which is good but they are recruited through a firm in Nairobi so they have international rates...the Partnership Fund which you know they can use for their own discretion is paying lead consultants US \$600 to do this proposal” (Interview 22nd May 2008).

There are several points to take away from this account. Perhaps the most important from the perspective of this discussion, is that the added layers of red tape the GFATM has incorporated into the revised application process have resulted in at least two new financial costs to the applicant country: the outlay associated with ensuring broad stakeholder consultation and the expense involved in hiring external expertise. The former, as the following advert demonstrates, now means there is a need to conduct district reconnaissance missions and extensive field consultations.¹³¹

¹²⁹ USH 653 million is the found to be equivalent to US \$347,345.62 on 11th December 2009, using conversion site <http://coinmill.com>

¹³⁰ The 2002 *GFATM Framework Document* underlines that the transaction costs of the Fund will need to be assessed, including the cost associated with producing a proposal (GFATM 2002: 18). While the proposal process has indeed been assessed by the GFATM in a general way (GFATM 2006) I have been unable to locate any hard figures on the financial costs involved in producing a proposal.

¹³¹ Chapter Seven outlines the manner in which the GFATM has encouraged the inclusion of civil society representation on Uganda’s revised CCM. As that chapter will report, during the round 8



Global Fund for AIDS, TB and Malaria

Invitation to the Uganda Round Eight HIV/AIDS, TB and Malaria



Background: The Global Fund to Fight AIDS, Tuberculosis and Malaria provides additional resources to fight three of the world's most devastating diseases and to direct those resources to areas of greatest need. As a partnership between Governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing. The Global Fund has now called for Round 8 grant application proposals. **The closing date for submission to Geneva is 1st July 2008.**

District reconnaissance missions and national level Consultative processes have been going on over the last two months and the Country Coordinating Mechanism for the Global Fund invites key stakeholders listed below to regional consultative meetings to contribute to the development of the Global Fund Round 8 Country Proposal.

The aim of the Global Fund round 8 proposal is to effectively foster implementation of National Strategic Plan for HIV/AIDS, Health Sector Strategic Plan II and Other Sector Programme Implementation Plans through increasing access, coverage, equity, safety, quality and realise equitable and sustainable impact.

The objectives of the field consultations will be;

- To obtain nationally generated and representative priorities for Uganda
- To agree and gain consensus on round eight priorities for Uganda
- To enlist meaningful engagement of local governments in the R8 proposal development process
- To ensure active involvement of lower, district-based and district-focused civil society organizations in identifying and defining national priorities for AIDS, TB and Malaria for R8.

The consultative process is a continuous one and information on priorities can be forwarded to the CCM secretariat on the contacts below till the **second week of June 2008**. A national level consultative will be conducted and the dates and venue will be communicated

Who is invited to participate?

The Chief Administrative Officer (CAO) is requested to mobilize and select 5 participants from among the following as district participants for the one day meeting:

1. District Health Officer
2. District Planner
3. Community Development Officer
4. Medical Superintendents of Regional Referral Hospitals
5. Regional TB Coordinator

The following civil society agencies are requested to select 1 participant each to participate in these consultative one day meetings.

6. UNASO representative
7. PHA Network representative
8. CBO representative
9. AMICAAL
10. Private Sector representative
11. MACIS
12. Stop TB Partnership CSO
13. PNFP/FBO Representative

All participants are requested report to the meeting venue by 4.00pm of the previous day. The detailed

program will be delivered to the Chief Administrative Officer for circulation.

Meeting Schedule and Venue

The following regional meetings will be held on the **Wednesday, 28th May, 2008** at the venues indicated:

- | | |
|------------|--------------|
| 1. Masaka | Hotel Brovad |
| 2. Jinja | Sunset Hotel |
| 3. Central | Ridar Hotel |
| 4. Soroti | Soroti Hotel |
| 5. Gulu | Acholi Inn |
| 6. Hoima | Kolping |

The following regional meetings will be held on the **Friday, 30th May, 2008** at the venues indicated:

- | | |
|---------------|---------------------|
| 1. Mbarara | Pelican Hotel |
| 2. Mbale | Mt. Elgon Hotel |
| 3. Lira | Lira Hotel |
| 4. Arua | Ombachi |
| 5. Fortportal | Vinka Social Centre |

The national consultative meeting targeting Kampala district, line Ministries, development partners, other national level public agencies, and national CSOs will take place on the **4th of June 2008 at Hotel Africana**.

For ease of reference and district groupings find the information below ;

1. Arua (6)

- a. Adjumani
- b. Arua
- c. Koboko
- d. Moyo
- e. Nebbi
- f. Terago- Maracha
- g. Yumbe

2. Central (7)

- a. Kayunga
- b. Luwero
- c. Mpigi
- d. Mubende
- e. Mukono
- f. Nakaseke
- g. Wakiso

3. Fort Portal (6)

- a. Bundibugyo
- b. Kaborole
- c. Kamwenge
- d. Kasese
- e. Kyaka
- f. Kyenjojo

4. Gulu (5)

- a. Amuru
- b. Gulu
- c. Kitgum
- d. Pader

5. Hoima (7)

- a. Bullisa
- b. Hoima
- c. Kagadi
- d. Kibale
- e. Kiboga
- f. Masindi
- g. Nakosongola

6. Jinja (7)

- a. Bugiri
- b. Iganga
- c. Jinja
- d. Kalro
- e. Kamuli
- f. Mayuge
- g. Namutamba

7. Kampala

- a. Kawempe
- b. Makindye
- c. Nakawa
- d. Rubaga
- e. Line Ministries
- f. National umbrella agencies, CSOs and networks

8. Lira (6)

- a. Amolatar
- b. Apac
- c. Dokolo
- d. Lira
- e. Oyam

9. Masaka (5)

- a. Kalangala
- b. Lyantonde
- c. Masaka
- d. Rakai
- e. Sembabule

10. Mbale (11)

- a. Budaka
- b. Bududa
- c. Bukwo
- d. Busia
- e. Butaleja
- f. Kapchorwa
- g. Manafwa
- h. Mbale
- i. Pallisa
- j. Sironko
- k. Tororo

11. Mbarara (10)

- a. Bushenyi
- b. Ibanda
- c. Isingiro
- d. Kabale
- e. Kanungu
- f. Kiruhura
- g. Kisoro
- h. Mbarara
- i. Ntungamo
- j. Rukungiri

12. Soroti (10)

- a. Abim
- b. Amuria
- c. Bukedea
- d. Kaberamaido
- e. Kabongo
- f. Katakwi
- g. Kumi
- h. Moroto
- i. Nakapirriti
- j. Soroti

For more information contact:

OR

Permanent Secretary
Ministry of Health
Plot 6 Lourdel Road,
Wandegeya
P.O. Box 7272
Kampala Email: ps@health.go.ug
Website: <http://health.go.ug/>

Director General Uganda AIDS Commission
P.O. Box 10799
Salem Bay Road Plot 2/3 Ntinda
Email: uac@uac.go.ug
Website: www.aidsuganda.org
Tel: 041 4 288 065 / 075 1 919 925

Figure 2: Advert for regional consultative meetings to contribute to the development of the GFATM Round 8 Country Proposal (The New Vision, 19th May 2008, p20)

proposal development, the CCM representative for civil society requested US \$500,000 for the purpose of consulting their constituents in Uganda, although this request was turned down.

The latter cost is indicative of a general rule of thumb in development, namely that anything involving funding can be turned into a specialisation. That local consultants can charge international rates demonstrates firstly, that the knowledge required to produce a successful proposal is perceived (rightly or wrongly) to be arcane. And secondly, that GHIs such as the GFATM have multiple distortionary effects in recipient countries - in this instance the envisaged reward has driven up the amount the country is willing to invest/gamble in/on its proposal (and created a lucrative job market for would-be consultants).¹³²

Another salient issue flagged up in the last except is the interviewee's suggestion that the "Partnership Fund" is covering the salaries of the lead consultants. It is not made explicit in this instance but the interviewee is most likely referring to the AIDS Partnership Fund, a voluntary basket fund that Uganda's AIDS Development Partners pay into, situated within the Uganda AIDS Commission.¹³³ Uganda's Health Development Partners also maintain a Partnership Fund, situated in the Department of Planning at the Ministry of Health, but it is a much smaller pot, originally conceived of (as once they both would have been) to cover the administrative costs of partnership/coordination at the country level over the course of a given year.¹³⁴ Indeed, the key difference between the two funds is that the former boasts a dedicated budget line for GFATM proposal development, while the relatively small

¹³² Other distortionary effects attached to GHIs regard fiscal ceilings (GHI additionality is hard to prove) (Nabyonga *et al.* 2009) and human resources for health (with GHIs accused of hiking up wages in the private sector) (Biesma *et al.* 2009).

¹³³ The AIDS Partnership Fund was envisaged in a similar manner to the health sector Partnership Fund detailed below. Its specific uses are laid out in Doc 2 of the LTIA's (Doc 2 2006: 7). An interview underlined the voluntary nature of the fund, so currently ADPs Irish Aid, DFID, Danida and the salient UN agencies were contributors (SIDA had just noted its interest to contribute) but USAID was not. Indeed the US agency was not permitted to donate to the fund and was instead contributing to the Uganda AIDS Commission's Integrated Work Plan (Irish Aid Interview 20th May 2008).

¹³⁴ The Department of Planning within the MoH submits a budget to the HDPs each year, detailing what ideally would be funded in the Partnership Fund and the HDPs donate as they see fit, again on an ad hoc basis (even giving at different times of the year and topping up if necessary). The health sector Partnership Fund is traditionally quite small, and intended only to cover the administrative costs of Partnership in the sector, so for instance paying for annual reports, coordination events such as the Joint Review and Technical Missions etc (Interviews 10th April 2008 and 22nd May 2008). Notably, a Ministry of Finance interviewee suggested that the Partnership Funds cover the "speciality costs" of partnership, which are not a top priority of the government (MoFPED Interview 25th April 2009). Walt *et al.* allude to the widespread existence of such funding, saying: "Ministries of health need to be prepared to devote substantial resources, time and energy to coordinating and managing resources...donors can be called upon to help, for example, by earmarking resources for aid management and coordination activities" (Walt *et al.* 1999b: 282).

contributions the Health Development Partners make to the latter - and their vocal objections to the escalating costs attached to the proposal - confirm that their Fund was never anticipated for the purpose now being suggested.¹³⁵

Nonetheless, I would argue that the appropriation of either fund to produce the Round 8 proposal has been a reactive, rather than pro-active shift on the part of Uganda to adjust to the - as yet - uncapped demands of the GFATM. This is further evidence of the aid instrument – through a lack of clarity – dragging the applicant countries along with it on its “learning curve” (Donoghue et al. 2005: 10). It is also the first concrete example evoked by the case study material of the GFATM piggybacking on the coordination infrastructure established to facilitate the health and HIV/AIDS partnerships in Uganda.

To weigh in now on the side of the GFATM, it could feasibly be argued that it was the decision of Uganda’s health and HIV/AIDS partnerships to hire external consultants to prepare the country’s Round 8 proposal, and that the expertise required to develop a successful proposal already exists in country. This is a credible argument but one that doesn’t hold up to scrutiny in the Uganda case study. Firstly, because it presumes that the national programmes for HIV/AIDS, tuberculosis (TB) and malaria have an unlimited amount of time to dedicate to the proposal. Secondly, because it suggests a level playing field, whereby each of the national disease programmes boasts an equality of financial, human and technical resources, when in fact nothing could be further from the truth.¹³⁶ The HIV/AIDS field is notoriously replete with donors (MacKellar 2005 identifies it as the top priority for international health assistance) – boasting three GHIs worldwide (two in Uganda) - and this translates into additional human and financial resources at the country level. So much so that I would posit that the more funding that already exists for a disease in

¹³⁵ The Chair of the HDPs was referring the Partnership Fund for the health sector when he suggested that coordination between partners in Uganda was “expensive in time but not money” (10th April 2008). The Chair of the AIDS Development Partners underlined that whereas the ADPs Fund contained a budget for proposal development, the HDP Fund had not been set up with that function in mind. She does note however, that the HDPs were “beginning to realise this is something they need to have” (Interview 20th May 2008).

¹³⁶ Even back in 2005 Donoghue *et al.* had noted that: “During proposal development, there has been a disease imbalance on the CCM with no voice and lack of technical expertise for malaria” (Donoghue *et al.* 2005: 43).

country, the better the chance of GFATM funding success for that disease. It's a controversial hypothesis and one that stands in overt opposition to the reputation of the GFATM as a 'gap filler'.¹³⁷ Nevertheless, the empirical evidence at the country-level in Uganda supports it.¹³⁸

Consider again the Round 8 application. The Chair of the AIDS Development Partners recounted a problem the malaria and TB partners were having mobilising the requisite resources to prepare their parts of the integrated proposal. In sum she noted that while the AIDS Partners had a dedicated budget line in their Partnership Fund for developing the HIV component of the proposal - and had previously bankrolled the proposal for all three disease components in Round 7 – the Health Partnership was being asked to fund the malaria and TB components of the GFATM proposal for the first time, causing real difficulties. Rather late in the day (the deadline for the Round 8 proposal was 1st July 2008 and this conversation took place toward the end of May 2008) she noted that the Private Secretary of the Ministry of Health had said: “she was going to look around for funding, so that we could jointly fund this process” (Irish Aid Interview 20th May 2008).¹³⁹ The contrast in funding available for the individual disease components was aptly demonstrated therefore in the report that the malaria and TB programmes had engaged consultants for just one to two weeks of the Round 8 proposal preparation while HIV/AIDS had budgeted for consultants to see the process through to completion. Moreover, to zoom in on the TB component in particular, it was clear from the anecdotal accounts that even the idea of contracting external expertise for TB was a new development in Uganda. A

¹³⁷ The *Five-Year Evaluation of the GFATM* reiterates the original vision that: “The Global Fund would serve to fill funding gaps in otherwise partner-financed country programs conceived and packaged coherently through ‘Country Coordinating Mechanisms’ led by governments and inclusive of civil society and the private sector” (Macro International 2009: 12). Nonetheless, the role of the GFATM as a “gap filler” is up for dispute. For instance, Oomman *et al.* found the GFATM “disproportionately focused on [HIV/AIDS] treatment and care at the expense of prevention.” Noting the same bias in the PEPFAR and World Bank MAP programmes, the authors found this “somewhat surprising given that the Fund’s money is intended to fill financing gaps, and treatment is well-funded relative to prevention” (Oomman *et al.* 2007: 62).

¹³⁸ Clearly we can’t say the same is true of other GFATM countries. Oomman *et al.* underline that the manner in which GFATM programmes are implemented in case study countries may not be indicative of practices elsewhere (Oomman *et al.* 2007: 5). That is why all GFATM assessments tend to adopt a purposive case study approach.

¹³⁹ The Permanent Secretary of the MoH is also the Chair of the Health Policy Advisory Committee which, as I shall go on to explain, has been designated one half of the CCM in Uganda.

WHO staff member recounted the more typical experience of putting together the TB proposal:

“Unfortunately it’s a very tedious exercise because usually it’s a small team and you have a number of volunteers from partners who are actually not paid. I’ve never seen them paid. They’re not given anything. And sometimes it’s so tedious. It will be like weekends – Saturday and Sunday – so you find the [national] programme manager sitting alone with the programme officers. The partners of course they are coming on a voluntary basis so they can’t be here all the time...And sometimes it goes on until about 9pm and you’re seated in the office trying to make a deadline” (WHO Interview 1st October 2007).

The same interviewee went on to say “I think HIV/AIDS, because they are more funded - they have more resources – I think they pay people to review those things, which does not happen in TB because in TB you rarely find that money easily available to assist in like that process” (WHO Interview 1st October 2007).

The comparative advantage of the already well-supported HIV programme is evidenced once again in this vignette concerning TB, which in this instance addresses the post-GFATM application process. It relates to the period following the approval of Uganda’s TB proposal for Round 6. The Round 6 grant release was delayed in Uganda first by the typical back and forth between the GFATM and the country to meet conditions precedent before sign off but then again by three events in country. Firstly, a partner charged with sending a final clarification to the GFATM forgot to do so, leaving the country and returning before the mistake was finally realised. Secondly an agreement sent by the GFATM for the country’s approval went AWOL in country for two months, with no one from the TB programme even aware it had arrived (the GFATM eventually called Uganda to ask what the hold up was). Thirdly, a requisition for TB monies sent from the MoH to the Ministry of Finance – Uganda’s Principal Recipient – languished on a desk for three months until the WHO Representative for Uganda asked that someone find out what was delaying the signing of Round 6. While the interviewee who recounted this tale was open that the latter delays were no fault of the GFATM, he did underline that they pointed to a serious capacity problem in the national TB response, which he likened to a “pipe

where the communication is passing is very, very, very, very narrow” (WHO Interview 22nd April 2008).

The point of including this account at this point is simply to posit what might be the likelihood of a similar chain of events unfolding with regards to an HIV/AIDS grant? Given the national HIV/AIDS program’s wealth of resources, multiple donors and dedicated AIDS Commission I would suggest not likely at all. In sum, I would confer the same advantages to the HIV/AIDS programme in developing a GFATM proposal.

It is interesting to the overarching theme of this thesis that it was the WHO Representative who emerged as the saviour in the TB Round 6 saga – maintaining an interest in the theoretical promise of GFATM funding long after the TB partners who had drafted the proposal had become reabsorbed into the every day business of implementing the programme. In Chapter Six, I highlight the growing impetus for the UN’s Specialised Agency for Health to demonstrate “added-value” (WHO Interviews 19th October 2007 and 12th November 2007) in a sector increasingly typified by multiple voices and skewed funding opportunities, which it is attempting to do by re-emphasising its first core function, “to provide leadership on matters critical to health and to engage in partnerships where joint action is needed.”¹⁴⁰ Now however, I will briefly focus on how WHO is operationalising this mandate with regard to the GFATM in Uganda.

Levelling The Playing Field and Filling the Void: The World Health Organisation’s Unfunded Mandate in Support of the GFATM

The Five-Year Evaluation of the GFATM found that the Fund’s evolution has been reactive and lacking in strategic vision (Macro International 2009). In contrast, I would posit that the WHO’s policy regarding the GFATM (and other GHIs) has been at once responsive and strategic. Even a cursory examination of WHO’s work in Uganda attests that the organisation’s country office has been proactively responding

¹⁴⁰ <http://www.who.int/about/role/en/index.html> [Accessed 19/02/09]

to the demands and deficiencies of the GFATM and conferring collective benefits to the Health and HIV/AIDS Partnerships in the process.¹⁴¹ In its simplest sense, this has meant helping the under-resourced TB programme attract GFATM funding by providing the supplementary TA the national programme couldn't afford to hire externally – in essence, helping to level the playing field for the most under-resourced of the 'big three'. At its most serious, it has meant WHO temporarily assuming the role of third-party procurement agent for the GFATM following the 2005 suspension - thus instrumentally restarting the flow of GFATM monies to Uganda.

The demands placed on WHO country offices (WCOs) and their partners by the GFATM at the country level were formally recognised in 2008 with the launch of *Maximizing Positive Synergies Between Health Systems and Global Health Initiatives* (WHO 2008), yet the Ugandan case study material establishes that WHO's central and regional tiers have been helping host countries and their WCOs to navigate the GFATM application process for several years now via the issuance of trainings and guidelines. This facet of WHO's work epitomises its efforts to fill the void created by the GFATM's lack of strategic foresight, by assisting countries to access the funding to which they may be eligible but which they are nevertheless struggling to access.

To return again to GFATM proposal development, the interviews revealed that WCO staff were involved in the preparation of all three disease components in Uganda. Moreover, they revealed that salient in-country staff had been sent on WHO-facilitated trainings to learn how to produce successful country proposals. The WHO National Professional Officer (NPO) for TB recounted how he had been sent on three trainings, in Geneva, Harare and South Africa. When asked what he had learnt, he replied:

¹⁴¹ Please note that WHO is considered both a Health Development Partner and an AIDS Development Partner in Uganda, despite bringing no financial advantage to either partnership. It is the organisation's technical expertise that makes it a natural shoe-in to each group. By including the WHO case example I hope to demonstrate that involvement with the GFATM is incurring partners with individual and collective costs; moreover, that by filling the information vacuum left by the GFATM, the WHO Uganda – as an individual HDP/ADP - is conferring benefits to the collective Health and AIDS Partnerships in Uganda.

“I think one of the things one learns there – let me say negatively – is the things that one should avoid putting in... You know we have a short time so it must be clear what you want to do and it must be clear how you arrive at your figures and so on. And if you are saying you want money it must be clear that it’s linked to your identified gaps” (WHO Interview 22nd April 2008).

The TB NPO explained that GFATM staff - for instance from the Technical Review Panel – had participated in the WHO organised trainings he attended, passing on their experiences of having reviewed GFATM proposals. The implication was that the trainings had helped Uganda win a TB grant in Round 6.

The significance of WHO’s in-house trainings to Uganda was impressed more fervently by an NPO for malaria, who argued for causation rather than correlation between the trainings and the country’s recent funding success in GFATM Round 7 for malaria:

“For Round 7 we got some training. I was in Harare...and then eventually we went to Nairobi. Yeah that’s what we did. That’s why we wrote a successful proposal. Remember malaria Round 5? We didn’t get it...Round 6? We didn’t get. So this time, Round 7 we said, ‘We must get it!’ So that’s why we put a lot of time and energy and got it” (WHO Interview 6th May 2008).

Similarly, the importance of WHO’s contribution to the development of the HIV/AIDS proposal was also impressed by a salient NPO, “WHO has I think been key in developing the HIV/AIDS Round 7 grant proposal technically and financially. And if we get the money from that it’s really WHO - ok with partners - but I mean if WHO had not pushed...” (WHO Interview 7th November 2007).

Clearly one should anticipate that interviews conducted at WHO’s Uganda country office are subject to a degree of subjective bias. Nevertheless I would at least surmise that the WHO trainings would not have been offered to country staff if a need had not been identified. An inconsistent record of funding success in the GFATM’s early

years of operation in Uganda suggests that WHO was attempting to respond to a genuine deficiency at the country level.¹⁴²

A related point to emerge from the WCO interviews suggests that while confusion over funding guidelines may have at times hampered Uganda's application attempts – thus necessitating training for WCO technical staff to assist the national proposal development - a continued lack of clarity surrounding the GFATM at the country level was now proving detrimental to grant utilisation. This points to a further gap in the GFATM approach:

“Definitely Global Fund is not well utilised because people don't even know what they can have...People don't read things. They don't know. They don't know...that they could have much more, even for health system development, even for support activities. They don't read, except those that write the proposal – who read the document – but otherwise no one reads what's available, what's possible, what's impossible” (WHO Interview 7th November 2007).

To sum up, the WCO interviews underscore firstly what was already suspected - that specialised knowledge is now needed to win GFATM funding. Hence the imperative for the WHO to provide staff trainings and – as evidenced in an earlier section - the pressure on country partners to fund external consultants to provide a similar function. This again points to the growing professionalisation of the GFATM application process. More disconcertingly however, the latter excerpt also suggests that the specialised knowledge now needed to develop a successful country proposal is confined to the select few. In short, there appears to be a disconnect between the form-fillers and the grant implementers, which could seriously undermine the potential of GFATM monies. Riddell 2007 has also pointed to the existence of such a

¹⁴² As suggested, Uganda has submitted 16 (disease-specific) applications over 9 funding rounds, of which 8 have been successful. To attach figures to the grants: Malaria has been successful in two GFATM rounds (2 and 7); of the \$286,250,427 Uganda has requested in total, \$212,100,635 has been approved. TB has also been successful in two rounds (2 and 6); of the total \$24,723,519 Uganda has requested, \$12,795,127 has been approved. HIV/AIDS has been successful in three rounds (1, 3 and 7); of the \$336,633,357 requested, \$165,518,234 has been approved.
<http://www.theglobalfund.org/programs/portfolio/?countryID=UGD&lang=en> [Accessed 24/11/09].

disconnect in development (although in relation to the development profession more broadly).¹⁴³

With regards to the GFATM, the chasm of knowledge that exists between the form-fillers and the implementers was exemplified in an anecdote concerning the aftermath of HIV/AIDS' successful Round 3 approval in Uganda when it was remarked that national bodies didn't realise they, like civil society organisations, had to apply to receive their share of the funding. Certain ministries – feeling that “they were important” – overlooked this technicality and risked missing out on funding altogether (WHO Interview 7th November 2007).

In addition, as the latter excerpt surmises, it also seems likely that national bodies are missing out on funding opportunities in health system strengthening (HSS) due to a lack of understanding about what exactly the GFATM funds. This is hardly surprising given the GFATM's uncertain foray into this area. Once again therefore, the proactive approach of WHO to counter the detrimental effects of GFATM confusion is admirable – a glance through WHO's international website reveals an array of technical support materials entitled: “Support for the Global Fund Round 9 call on health system strengthening,” aimed at helping applicant countries put together their HSS applications.¹⁴⁴ In *Maximizing Positive Synergies* WHO makes an explicit mention of the continued confusion surrounding GHI's strictures, stating “countries would benefit from receiving more explicit guidance for the range of issues for which they may request funds from each GHI, as well as from greater clarity on funding options for supporting health and community systems” (WHO 2009: 3). During the interim, it would seem that WHO has taken up the mantle on behalf of the GFATM.

On the one hand, the manner in which WHO has responded to the GFATM could be viewed as epitomising the Fund's original conception of the partnership model, yet

¹⁴³ “The growing acknowledgement of the complexities of development has led to increased specialization with the development profession. But this has also led to the compartmentalization of different subgroups within the fields of development, often leading to isolation from, ignorance about, and sometimes even indifference to other dimensions of development” (Riddell 2007: xvi).

¹⁴⁴ http://www.who.int/healthsystems/gf_round9/en/index.html [Accessed 25/11/09].

WHO's *Maximizing Positive Synergies Initiative* plainly belies this notion by suggesting that any success the GHI has enjoyed with partners to-date has come about by happy accident rather than design: "In the absence of any common Framework, many of the benefits [attributed to GHIs] are being derived more as a result of positive spill-overs than from proactive and strategic work..." (WHO 2008: 8).¹⁴⁵ Indeed, the lack of strategic vision has clearly proved costly to WHO and partners, hence the affirmation that "The time has come to move from the current situation where outcomes are often subject to trial and error and reliant on goodwill, to a more systematic framework of active management by all stakeholders" (WHO 2008: 8).

The financial and opportunity costs incurred through the trial and error approach of GHIs such as the GFATM were first recognised in 2005, when the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors identified the UN's "unfunded mandate" (GTT 2005: 15). This relates to the mismatch between the need and availability of UN technical support being requested by countries to finance proposal development and to support the scale up of HIV/AIDS responses in accordance with the GHIs. In short, the GTT noted that the rise in demand didn't correlate with any additional resources for the UN system; hence the UN's "unfunded mandate", which in 2005 was estimated to stand at US \$166.4 million over a period of two years (UNAIDS 2005: 2). The notion of an unfunded mandate in relation to the GFATM has since been deemed applicable to other partner organisations (Shakow 2006).

In the context of Uganda, I would argue that WHO's unfunded mandate is more serious than an unmet financial outlay and is in fact contributing to a distortion of its core mandate, yet to be fully appreciated. Such distortion is well exemplified in the following statement by a WCO national professional officer, who assured me that: "it is one of our core activities to support the Ministry [of Health] in resource

¹⁴⁵ Through the Maximizing Positive Synergies Initiative the WHO aims: "to identify where there are positive synergies between health systems and Global Health Initiatives and to foster the systematic exploitation of these synergies to ensure maximum, mutual added value and commensurate gains for public health" (WHO 2008: 6).

mobilisation” (WHO Interview 6th May 2008). Yet even a quick glance through WHO’s six core functions alludes that this is a tenuous interpretation of the organisation’s original remit, meaning the multiple months the agency is now dedicating to GFATM applications should be a cause for concern (particularly when winning a GFATM grant is far from guaranteed).¹⁴⁶ Moreover, if one now considers the role WHO Uganda has played in attempting to regain GFATM confidence in the country following the 2005 suspension, its decision to assume the role of third party procurement agent for the GFATM while national capacity improves (or at least until the post can be put out for competitive tender) takes on a new resonance. Asked about this unexpected role – which WHO had originally agreed to take on for one year but which it was found to be continuing to do past the original deadline of 30th September 2007 – the Drugs and Essential Medicines National Professional Officer at WCO noted:

“We are not comfortable with continuing because it’s not consistent with our core mandate. We only came in because we were to fill a gap and help the government not to lose the money. It has consumed a lot of our time and because it is not our core mandate we have not done it so well” (WHO Interview 8th November 2007).

The international reputation of WHO was the deciding factor in the GFATM entrusting it with the responsibility of third-party procurement agent in Uganda yet WHO’s reputation is a consequence of its adherence to its core functions and comparative advantage. Subsequently, by inducing WHO to deviate from its clear remit, the GFATM threatens to undermine the very reputation it is entrusting. This is troubling given the GFATM’s muted hostility to the UN agency, as highlighted in the *Five-Year Evaluation of the GFATM* (Macro International 2009). From this

¹⁴⁶ The Core Functions of WHO: 1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed; 2) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge; 3) Setting norms and standards and promoting and monitoring their implementation; 4) Articulating ethical and evidence-based policy options; 5) Providing technical support, catalysing change, and building sustainable institutional capacity; and 6) Monitoring the health situation and assessing health trends. <http://www.who.int/about/role/en/index.html> [Accessed 19/02/09].

vantage point the GFATM's partnership model regarding the UN agency starts to appear slightly parasitic. *Maximizing Positive Synergies* – in which WHO appoints itself as the lead agency in another global coordinated response – can therefore be viewed an effort to off-set the worst failings of the aid instrument by drawing upon another by-product of the coordination ethos - coordination to build policy consensus – whereby WHO is attempting to drum up some collective pressure on the Fund (and GHIs more broadly) to reform.¹⁴⁷

In addition to facilitating the restart of GFATM monies to Uganda following the 2005 suspension by acting as the Fund's third-party procurement agent, it is important to note that the WCO - together with other Health and AIDS Development Partners - assisted the national process of regaining GFATM confidence through the development of the Long-Term Institutional Arrangements (LTIA) during 2006 and 2007 (indeed it was the LTIA that formally established WHO as procurement agent (Doc 1 2006: 25)). The LTIA, which establish that the national health sector and HIV/AIDS coordination forums become Country Coordination Mechanism for the GFATM, attest that it is not only the core functions of the UN's Specialised Agency for Health that risk being distorted through sustained involvement with the GFATM at country level.

Uganda's Long-Term Institutional Arrangements

Devised originally for the GFATM and now heralded as the blueprint for all aid-centric relations in Uganda, the overriding principle underpinning the LTIA is "the realignment of all funding mechanisms to existing institutional arrangements,

¹⁴⁷ WHO plan of action for *Maximizing Positive Synergies* is three-fold and signals a reaffirmation of the organisation's core functions: a two-part evidence gathering process, whereby existing evidence on the GHIs is gathered and then new research commissioned to address the obvious gaps, will be complemented by a broad international consultation. WHO will lead this process, drawing upon its "convening power to bring together both the knowledge and the individuals and organizations that have a role to play in the evidence gathering and subsequent policy development" (WHO 2008: 10). This initiative epitomises the manner in which WHO is increasingly having to work within the new aid architecture, where fostering partnerships and showing added value have become essential to the organisation's ability to exert policy influence at the international level in the face of skewed funding incentives (most often typified by GHIs) and multitudinous voices. See Chapter Six for further discussion.

thereby minimizing duplication and fragmentation of efforts” (Doc 1. 2006: 5).¹⁴⁸ In short - and in keeping with the alignment principle promoted in the Paris Declaration - the central message is that aid donors should use existing systems and structures within Uganda, contributing to national capacity where needed. In accordance with this premise, it was decided that existing coordination structures in the Health and HIV/AIDS Partnerships should take on the role of Country Coordinating Mechanism (CCM) for the GFATM: with the Health Policy Advisory Committee (and its respective Technical Working Groups) subsuming CCM functions for the management of the TB and malaria grants, and the Partnership Committee of Uganda AIDS Commission (and its respective working groups) subsuming respective functions for Uganda’s multi-sectoral HIV/AIDS response.¹⁴⁹ While this set-up may give the false impression that there are now two CCMs in Uganda, the LTIA establish that the forums simply make up two halves of the one whole.¹⁵⁰

The LTIA set out an expanded scope of work for the HPAC and the PC in line with their revised remit as CCM. Indeed, a cursory look at the guidelines for the HPAC, which establishes seven additional, CCM-specific duties, signals a clear increase in workloads for both fora (see box 11).

¹⁴⁸ Rather than being contained in one document, the LTIA have been refined via a series of documents, which express the iterative exchange the country was engaged in with the Global Fund Secretariat during 2006 and 2007. I draw on five of those documents in my thesis. References for these are to be found in an annexed section at the end of the main bibliography.

¹⁴⁹ While it is not a focus of this discussion, it is perhaps significant to the future working relationship of the MoH and the UAC within a joint CCM that Donoghue *et al.* (2005) noted tension between the MoH and UAC back in 2005 as each wrestled for control and funds in the unclear division of labour surrounding the GFATM. It is significant therefore that the minutes of a HDP meeting in 2008 reported that the current relationship between Uganda’s MoH and UAC was judged as: “not encouraging” (Minutes of the Health Development Partners Group Uganda 8th January 2008).

¹⁵⁰ The linkage between the HPAC and PC is articulated as follows: “The UAC will be at the same level as HPAC on matters of HIV/AIDS and there will be two way communication on policy issues relating to HIV/AIDS as the 2 organs subsume the roles of the CCM” (Doc 3 2006: 12). That said, to ease any confusion at the level of the GFATM secretariat with the arrangement, the Chairperson of the HPAC – the Permanent Secretary of the Ministry of Health – is identified as the channel of official communication to the GFATM. Although again the equal importance of the PC is stressed: “It is important to note that this memorandum is not a legal document meant to reduce the statutory mandate of the PC. It is meant to have a smooth and consistent communication channel to and from GF Secretariat” (Doc 4 2007: 16). In Chapter Four I underline that appearing to speak with one voice is a central tenet of the coordination principle, conferring partners with the advantage of strength in numbers and protecting against divide and conquer tactics.

Box 11: Additional Duties for the Health Policy Advisory Committee in line with Appointment as Country Coordinating Mechanism for the Global Fund

1. Overall Global Fund programme oversight, coordination and development
2. Overseeing the development of proposals to the Global Fund
3. Review and approve project proposals to Global Fund
4. Review and approve Global Fund work plans
5. Monitor and evaluate progress and implementation of projects funded by Global Fund, within the framework of implementation of the Health Sector Strategic Plan
6. Review and approve Global Fund progress reports
7. Make decisions on renewal or applications to Global Fund and approve such applications

Source: Doc 3. 2006: 7

The new responsibilities far exceed the proposal development stage that forms the basis of this discussion and point to long-term oversight and reporting commitments on behalf of the GFATM Secretariat.¹⁵¹ As with the use of the health and HIV/AIDS Partnership Funds for funding proposal development, this development equates to the piggybacking of the GFATM on the coordination structure underpinning Uganda's health SWAp and multi-sectoral HIV/AIDS response. This begs the question: how has the appointment of the two coordination forums as CCM impacted in Uganda?

The first thing to note about the arrangement found in place during the fieldwork period is that CCM activities were never intended to be dominant items on the individual HPAC and PC agendas. Instead, CCM business was supposed to be confined to quarterly meetings held under the official auspices of 'CCM', and to the occasional ad hoc meeting if and when the need should arise (Irish Aid Interview 20th

¹⁵¹ The suitability or otherwise of the current generation of CCMs to fulfil these duties is called into question in the *Five-Year Evaluation of the GFATM* which notes multiple problems plaguing the CCM model: the clarity over precise roles within CCMs remains unclear; CCMs are often still perceived as GF entities rather than entities for promoting country ownership; CCMs are often viewed as political rather than technical and thus are unsuited to overseeing grant implementation; and relations within CCMs can vary wildly, as do the capacities of different members to participate (Macro International 2009).

May 2008). However, the finding to emerge from the fieldwork interviews was that GFATM issues were consuming a lot more time in the monthly HPAC and PC meetings than initially expected.¹⁵² The situation was such that the Chair of the Health Development Partners (HDPs) highlighted it at the biennial meeting of the National Health Assembly in 2007. There, he underlined that while the HDPs were happy with the way HPAC had been reorganised following the CCM appointment (HPAC membership was expanded in accordance with the LTIAAs), they were nonetheless concerned that the GFATM was taking up a lot of time and energy in the HPAC forum, thus undermining its prescribed role to influence policy.¹⁵³ When asked whether things had improved during a subsequent interview with the HDP Chair in April 2008, his response was “No, not yet” (BTC Interview 10th April 2008). The problem he explained was that although the preliminary work of developing GFATM proposals was supposed to be completed at a lower level than the HPAC and PC - at the level of the technical working groups - some of the technical working groups were not yet operating well (meeting irregularly or not at all), meaning that technical issues concerning the GFATM were filtering up onto the HPAC agenda.¹⁵⁴ When asked whether he envisaged the problems with the technical working groups could be resolved in the foreseeable future, the HDP Chair replied “no,” the implication being that GFATM matters would likely continue to skew the agenda of the sector forum for some time.

Viewed at its most benign, the encroachment of the GFATM on the HPAC agenda can simply be construed as “really, really tedious” (MoH/Danida Interview 9th May 2008). This was the general opinion raised by HPAC attendees, and was most often accompanied by acquiescence that it was nevertheless right the forum should be one half of Uganda’s CCM.¹⁵⁵ Yet, the encroachment angle can also be viewed more

¹⁵² I need to qualify this point by saying that the fieldwork period fell in what might be termed the teething period of the new arrangements (which were operationalised in June 2007); moreover, that the end of the fieldwork coincided with the preparation of the Round 8 proposal.

¹⁵³ In fact the HDP Chair complained that the GFATM *and* GAVI were taking up too much time in HPAC. This point was raised during a panel discussion at the National Health Assembly meeting that took place on 24th October 2007.

¹⁵⁴ See Appendix 2 to see how TWGs fit into the overall Health Sector Organisational chart.

¹⁵⁵ One interviewee pointed out that this was the arrangement Uganda originally proposed to the GFATM: “Right from the beginning when the Global Fund indicated that they needed a CCM, for us, right from the beginning that’s what we would have preferred but they had their own ways of looking

seriously, in line with the HDP complaint that GFATM matters were undermining the prescribed role of the HPAC to determine policy. Indeed it was in this vein that a MoH official expressed his dismay that the HPAC forum - established to support the entire health sector - was still being dominated by GFATM issues (i.e. the ‘big three’) by mid-April 2008. These complaints point to a distortion of the forum’s core mandate that resonates with the previous WHO case study (Interview 16th April 2008). Whether or not this proves to be an interim distortion while the CCM arrangement matures in Uganda (and while the TWGs develop their capacity) it is nevertheless a disconcerting finding, and one that supports the WHO suggestion that GHIs have re-ignited the horizontal versus vertical debate over health (WHO 2009).¹⁵⁶ The notion that the GFATM is an anathema to the sector-wide approach is an issue that has been speculated upon time and again in the discourse.¹⁵⁷ Nevertheless, the decision to appoint the coordination forum as CCM is surely the best way for Uganda’s health stakeholders to reassert its commitment to the sector-wide approach by attempting to gain more ownership over the GFATM monies.

Uganda’s success in winning HIV/AIDS and malaria grants in Round 7 attest that the new LTIA has indeed sown the seeds for renewed GFATM confidence in the country. This is to be applauded, and it must be stressed that the government and its Development Partners are behind the LTIA and the idea of using national systems to manage the GFATM funds. Indeed, just to be clear, it was an integrated proposal and the use of country systems that the country originally proposed to the GFATM in its Round 1 proposal. The perverseness of the current situation is thus well encapsulated

at things, So it took quite some time for them to get back to that position...It’s right. That’s where it should be but it’s tedious” (MoH/Danida Interview 9th May 2008).

¹⁵⁶ See Oliveira-Cruz *et al.* (2003) for the main points in the horizontal and vertical debates.

¹⁵⁷ Donoghue *et al.* uncovered the belief that the GFATM had created an obstacle to ‘three ones’ in Uganda (Donoghue *et al.* 2005: 22). The GTT (2005) found that many GHIs were utilising a project approach, thus entrenching a vertical approach to HIV/AIDS and refusing to accept national plans over project proposals. At this time it advised GHIs to move from project to programme style aid. Oliveira Cruz *et al.* (2006) has suggested that the GHIs and their renewed interest in vertical funding “may adversely affect the SWAp and risk destabilising the significant progress made in the health system in Uganda since 2000” (Oliveira-Cruz *et al.* 2006: 29). A GFATM study remarked on concerns in recipient countries that the GFATM decision to provide funding in rounds was more in keeping with doing discrete projects than strategic programs, and was perceived to be “undermining coordinated approaches such as SWAps and causing disharmony for national planning, implementation, monitoring and reporting systems” (GFATM 2006: 17; also see WHO 2008, WHO 2009).

in the following statement of a MoH staff member, who, having worked in the same position for over a decade appears immune to the “historical amnesia” plaguing much of the aid industry (Easterly 2002: 49). She impressed that the LTIAAs were nothing new in Uganda:

“I don’t think they’re anything revolutionary, no. It’s like I said, five years ago – so when the Global Fund started – as a country we prepared one proposal for the three diseases with a systems approach, and we would have preferred to have run it through the government systems. We went to the Global Fund and they didn’t like it. They threw it out and they told us they wanted a whole separate back up. They went down that road, they were seriously burnt...they came back to ask how would we really like to go about it” (MoH/Danida Interview 9th May 2008).

This same position on the LTIAAs was reinforced repeatedly in the country interviews, in which interviewees often cited Uganda’s 2001 ‘Partnership Principles’ (MoFPED 2001) as the original template for the arrangements.¹⁵⁸ And while the turnaround in the GFATM’s approach to Uganda aptly epitomises the trial and error methodology of the Fund argued throughout this chapter, the acknowledgement of the “large-scale experiment” (Oomman *et al.* 2007: 3) fails to hint at the full range of costs incurred by the country and its development partners as its subjects. However, I would posit that even a cursory examination would view the 18 months of back and forth needed to reach agreement with the GFATM Secretariat over the LTIAAs – in short, to convince the Fund to accept the original *modus operandi* the country suggested five years earlier – as an unnecessary outlay. A working figure of loss would also have to estimate how much potential funding the country lost out on while the LTIAAs were being finalised and perhaps take into account the figure misappropriated as a result of the grants’ mismanagement, which is commonly blamed on the positioning of the Project Management Unit away from government oversight.

A final calculation might also take into account the money Uganda has spent on outsourcing financial and management expertise to manage GFATM monies while national capacity develops in line with the Fund’s expectations. Here I would point

¹⁵⁸ Please see Chapter Four for elucidation on Uganda’s ‘Partnership Principles’, which have served to guide donor-government relations since 2001. Also see box 5 on p96 for a copy of the Principles.

to the GFATM funding being diverted in Uganda to international accounting firms PricewaterhouseCoopers, Ernest and Young, and Deloitte and Touche. To elucidate, PricewaterhouseCoopers, while initially brought in to investigate the charge of mismanagement levelled against Uganda in 2005, has since been appointed Local Fund Agent for Uganda.¹⁵⁹ While following the suspension of grants in 2005, Ernest and Young was contracted by Uganda's Ministry of Finance to provide financial oversight on all GFATM monies. Finally, Deloitte and Touche has been appointed Technical Management Agent of the Civil Society Fund, a new basket funding mechanism for civil society in Uganda that will allocate and disburse GFATM monies (along with other donor monies).¹⁶⁰

The *Five-Year Evaluation of the GFATM* has attributed both the outsourcing of fiduciary and oversight functions and the dramatic growth of the GFATM secretariat (which has increased beyond original expectations) to the failure of the Fund to realise its partnership model (Macro International 2009).¹⁶¹ I however, would simply highlight how both developments have inevitably increased the overheads involved in managing the grants, leaving less money available for direct targeting of the 'big three'. In short, just as the increased bureaucratisation of the GFATM application process has hiked up the costs incurred by applicant countries so has the increased

¹⁵⁹ Concern has been voiced on the use of such firms as LFAs: "In about 80 percent of countries receiving Global Fund grants, representatives of global accounting firms are responsible for monitoring progress in project implementation... About 42 percent of the Global Fund's annual operating budget is spent on this function, While these agents perform many valuable functions, they are generally not well-equipped to assess and evaluate substantive development issues as they rely more on traditional accounting approaches" (Shakow 2006: 24). Shakow has also highlighted a concern over LFA "mission creep" in cases where it has been noted that LFAs have sought to become involved in proposal development and implementation. This is problematic first and foremost for country ownership but also because most LFA members aren't qualified to get involved in substantive matters (Shakow 2006: 22).

¹⁶⁰ See Chapter Seven for more detail on Uganda's Civil Society Fund.

¹⁶¹ The *Evaluation* comments on the dramatic growth of the GFATM Secretariat saying "Rather than addressing the tensions in the Global Fund's guiding principles and affirming the primacy of the partnership model it initially subscribed to, the Global Fund Board defaulted to a 50 percent per year increase in staffing..." It also notes that "Absent clear policy intent and despite concerns expressed by some members of the board, the Secretariat took the path of contracting out in-country fiduciary functions and hiring in additional program oversight capacities, rather than partnering with other international entities. What followed was a continuous cycle of Global Fund hiring in Geneva to catch up with the oversight requirements of the Fund's expanding portfolio, with the Secretariat to take on functions that arguably other partners were in a better position to execute on the Global Fund's behalf" (Macro International 2009: 36).

bureaucratisation of the Fund's governance structures - which have thus far proved reluctant to delegate meaningful responsibility to partners.

While spelling nothing new in Uganda, the LTIA's do hint at a new epoch in the GFATM's relationship with Uganda, where a concerted attempt is being made to improve national ownership of the aid instrument and its governance structures.¹⁶²

While this will likely prove to be a gradual process, there are renewed reasons for optimism. Case in point - the GFATM's "first learning wave" of National Strategy Applications, which seems particularly well suited to Uganda's mature health SWAp and multisectoral HIV/AIDS response.

National Strategy Applications and the Domino Effect of GFATM Round- And Performance-Based Funding

In November 2008, the GFATM approved the launch of the "first learning wave" of National Strategy Applications, representing a new way for countries to apply for grants. Information about the initiative was initially felt wanting on the GFATM site, nevertheless GFATM-observer NGO Aidspace went some way to filling the information void, explaining:

"NSAs involve submitting a national disease strategy itself – rather than a Global Fund-specific proposal form – as the primary basis of the application for Global Fund financing. NSAs are part of the Fund's efforts to streamline its applications and funding process" (Aidspace 2009a: 1).

Attesting therefore to a significant change in the GFATM application process, the NSA offers hope that the GFATM is now on course to honour its commitment on the 'Three Ones' principle promoted by the Joint United Nations Programme on HIV/AIDS and is, in the process, attempting to make the GFATM proposal process more applicant friendly.¹⁶³ This is great news, both in terms of the focus of this

¹⁶² Oomman *et al.* (2007) affirm the GFATM's commitment to foster country-ownership: "The Global Fund's philosophy of country-ownership is evident both in the variation across countries of the programmatic activities supported, and in the types of ROs [Recipient Organizations] that manage this funding" (Oomman *et al.* 2007: 42).

¹⁶³ The "Three Ones" principles are that countries should have: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS coordinating authority, with a broad-based multisectoral mandate, and one agreed country-level

discussion and the fact that Uganda fulfils several of the entry criteria for the pilot study: boasting strong partnerships with bilateral donors and technical agencies in-country to support the application process and grant implementation, and having at least one “well articulated and documented national strategy, developed through an inclusive process that runs through to at least the end of 2012” (Aidspan 2009a: 1).¹⁶⁴

A further criterion for entry into the “first learning wave” provides pause for thought however. This stipulates that participation in the pilot is open only to countries that applied for, but were unsuccessful in their application for Round 8. Given therefore that a large part of the empirical data used in this chapter addresses the period when Uganda’s Health and AIDS stakeholders were developing the country’s Round 8 proposal, it may come as somewhat of a surprise now to reveal that Uganda never actually applied in Round 8. Despite the months spent planning, the disruption in the HPAC and PC forums, the use of the Partnership Funds to contract external expertise and the fact that informed commentators from all three disease programmes indicated the country’s intention to apply for Round 8 funding, the final proposal was never submitted. More than any other study or vignette I can draw upon in this chapter, it is this single piece of information that attests to the cost of failure now associated with involvement with the GFATM experiment. Moreover as will shortly become apparent, this cost rarely results in a finite outlay in the applicant country. Instead as a consequence of the GFATM’s earlier choice to champion round and performance-based funding, failure appears to pre-empt subsequent failure, at least in the Uganda case study.

So what happened with Uganda’s Round 8 proposal? A newspaper account following the end of the fieldwork explained that:

monitoring and evaluation System.

<http://www.unaids.org/en/CountryResponses/MakingTheMoneyWork/ThreeOnes/default.asp> [Accessed 13/10/10] In 2005, the GTT complained that most GHIs were still utilising a project approach and refusing to accept national plans over project proposals.

¹⁶⁴ While Uganda does not have updated strategies for malaria or TB, it does boast the *National HIV/AIDS Strategic Plan 2007/8-2011/2012* (UAC 2007). It does also boast a now out-dated national strategy for malaria, which presumably could be built upon (MoH 2001).

“As a result of delays in the first seven rounds, Uganda could not apply for Round 8 grants, whose application deadline was July 1. ‘We are finalising with the Round 7 funding. Applying for fresh grants would be illogical...’ said a source at the Uganda AIDS Commission” (Wendo and Businge 2008).

Moreover, the article underlines that the compound effect of delay associated with GFATM funding goes back a lot further than Round 7:

“Out of \$36m allocated to the country in 2003 for HIV/AIDS activities under Round One, over \$10m has not been released as the Fund was not satisfied with how the first instalments were used. Another \$24 was allocated in 2004 for malaria activities under Round 2, but \$2m has not been disbursed...An official of the NGO [Aidspan] told the New Vision that due to the huge time lag, the withheld grants ‘have become irredeemable.’ ‘Uganda failed to satisfy the Global Fund in time that the arrangements put in place after the suspension were good enough to protect their money in Uganda.’...Uganda now hopes to get funds under Round 3 and Round 7” (Wendo and Businge 2008).

Clearly the matter is now hugely convoluted, evoking the notion of a domino effect of delays and failure. I will sidestep the decision of the GFATM to withhold some of the Round 1 and 2 grants - the backdrop to which is the 2005 mismanagement issue - focusing instead on the failure of Uganda to submit a Round 8 proposal despite all indications to the contrary and in spite of the new optimism surrounding the LTIAAs, which appeared to draw something of a line under the events of 2005. Here, I have identified two key issues: the delay in signing off on the approved Round 7 grants and the ramifications of that delay for future GFATM applications.



Figure 3: Cartoon alluding to the termination of two GFATM grants in Uganda

The Round 7 grants were approved in November 2007 amid much fanfare in the national press. The good news was that malaria had won all the funding it had requested, while HIV/AIDS had won a high proportion of its requisition. Yet as those au fait with GFATM funding procedures will be well aware, the announcement of GFATM approval doesn't signal immediate disbursement, and a process of back and forth to meet the Fund's conditions precedent is to be expected before signing. Moreover, signing doesn't signal immediate disbursement and another – although much shorter - delay is to be expected following this milestone.¹⁶⁵ An official based

¹⁶⁵ The GFATM explains the proposal process as going through the following stages: call for proposals; preparation; first screening; technical review; board approval; option for appeal; Local Fund Agent selection; Secretariat and PR negotiate grant agreement, which identifies specific, measurable results, to be tracked using a set of key indicators; grant agreement signed. Based on request from Secretariat, the World Bank makes initial disbursement to PR. PR makes disbursements to sub-recipients for implementation, as called for in the proposal; program launch; disbursement

in the Ministry of Health's Planning Department provided me with this timeline of when he expected Round 7 monies to start flowing to Uganda's PR: signing was expected in August/September 2008, following which a 3-month delay might be anticipated before actual disbursement (Interview 16th April 2008). Given that the country's application had been approved in November 2007, this estimation points to a full 12-month wait for the funds. Furthermore, as the interviewee who provided this insight reminded me, the Round 7 application had taken the country four months to prepare. In light of this 16-month timeline therefore, it is hardly surprising that the same official was heard to exclaim, "It's not worth it" (MoH Interview 16th April 2008).

If you now recall the earlier vignette about the multiple delays preceding the sign off on Uganda's Round 6 TB grant, it becomes clear that Uganda's experience with Round 7 is not without precedent. To recap, the TB Round 6 signing was delayed by a series of errors made in the applicant country. Yet even taking those into account, the finding that there was a wait of "one year and three-quarters" between submitting the TB application and grant disbursement seems excessive (WHO Interview 22nd April 2008). Inefficiencies in the GFATM's disbursement processes have been picked up in a number of studies including Uganda's *Global Fund Tracking Study*, which in 2005 was already illustrating how impediments to signing could delay the release of funds (Donoghue *et al.* 2005).¹⁶⁶

requests, progress report and annual audit; disbursement requests; extension of initial 2 year funding. <http://www.theglobalfund.org/en/rounds/applicationprocess/> [Accessed 20/01/09].

¹⁶⁶ Shakow (2006) finds that while the GFATM's approval is swift relative to other HIV/AIDS GHIs, its disbursement is slow, finding "The average time from approval to first disbursement is now 12.5 months. Thus, while speed was an important selling point when the Global Fund was founded...in some instances it has proven to be not that much faster than the Bank's MAP projects, and large amounts have sometimes sat around undisbursed..." (Shakow 2006: 26). WHO underlines however, that the problem is not specific to the GFATM and that the disbursement processes of most GHIs are "not optimal and would benefit from simplification" (WHO 2009). Oomman *et al.* on the other hand, while on the whole happy with the GFATM's disbursement processes, did note that they were slower than both the PEPFAR and MAP equivalents, "The Global Fund process is slightly slower and less predictable than that of PEPFAR and the World Bank since the approval of disbursement requests is subject to more thorough review..." (Oomman *et al.* 2007: 65). Nabyonga *et al.* (2009) have noted discrepancies between the provided budget and expenditure figures at the end of the financial year in Uganda's health sector, which are partly blamed on unpredictable GHI funding: "The GFATM and GAVI are examples with probabilities at several stages from grant approval, periodic disbursements, and phase-two continuation of grants" (Nabyonga *et al.* 2009: 8).

To return to the Round 7 country proposal, another interesting fieldwork finding concerned TB's unsuccessful Round 7 application. One respondent provided the following explanation for why he believed the TB application had been turned down in Round 7 despite the HIV/AIDS and malaria applications both being approved:

“We got feedback [from the TRP] although some people say one of the things that's not written in the feedback is that at the time of the application for Round 7, Round 6 had not been signed. So some people were saying we're probably not even wise at all to ask for more money when the other one is not signed even” (Interview 22nd April 2008).

It is remarkable that this statement essentially mirrors the comment of the UAC representative in the preceding newspaper excerpt, who suggested it was “illogical” of Uganda to apply for Round 8 before signing off on Round 7. Yet the fact that partners were still found to be developing the proposal by early June 2008 (the end of the fieldwork period) – one month prior to the Round 8 deadline – begs the question: why hadn't it been firmly impressed on Uganda that if a funding round has not been signed off upon, no applications for a subsequent round will be considered? Indeed, is this even a GFATM stipulation or rather a rule of thumb countries are deducing from their own experiences (from trial and error)? A confounding search through the GFATM guidelines provides little enlightenment. It is therefore disheartening to consider the wealth of resources and effort that Uganda's Health and HIV/AIDS stakeholders expended putting together the country's Round 8 proposal before pulling out at the last minute. Moreover, when pondering why Uganda decided against applying for Round 8 one should not dismiss the relative unpreparedness of the TB and malaria programs to develop their sections without sufficient technical expertise. It seems likely that the failure to apply was a combination of both factors, neither of which bodes well for the GFATM: that the country wasted so much time and money on a proposal that was suddenly perceived to have no chance of serious consideration is an indictment of the Fund's insufficient guidance; that the country's malaria and TB partnerships didn't believe they could put together a decent proposal without significant external expertise in the time allotted points to a flawed and overly complicated application process.

That the NSA may prove an application route more suited to the Ugandan context is irrelevant at this point as Uganda continues to play catch up on a series of signing and disbursement delays that show no sign of abating. Indeed a glance at the GFATM website attests that while Uganda did at least submit a proposal for Round 9, it was unsuccessful in all three disease components.¹⁶⁷ Viewed in this light the GFATM funding strictures (relating to round and performance-based funding) become analogous to the 400m hurdles - if you miss one hurdle it's likely you'll miss the next and the next. There's little opportunity for a fresh start or a clean slate, which is what Uganda was hoping for with the LTIA's. The flawed GFATM model is rapidly decimating the image of the Fund in Uganda in the eyes of government and donors alike. Moreover, it begs the question: what has happened to GFATM's commitment to allocate grants according to need?

The Tension Undermining the GFATM Vision: 'Needs-Based' Versus 'Quality Proposal-Based' Resourcing¹⁶⁸

The original GFATM Framework Document was clear that "In considering proposals the highest priority should be given to those proposals from countries and regions with the greatest need..." (GFATM 2002: 9). That there remains a need in Uganda is played out in the country's annual health statistics, which repeatedly point to resource gaps in the targeting of HIV/AIDS, TB and malaria. Nothing new there then, where the statistics have caused pause for thought in recent years is over reports that the country's HIV/AIDS prevalence rate has stagnated (the current figure is 6.4% (UAC 2007: i)).¹⁶⁹ Regularly heralded as the developing world's HIV/AIDS

¹⁶⁷ <http://www.theglobalfund.org/en/fundingdecisions/notapproved/#9> [Accessed 15/05/10]

¹⁶⁸ The *Five-Year Evaluation of the GFATM* notes that: "Notwithstanding some differences in view on 'needs based' versus 'quality proposal based' resourcing, there was a general expectation that competition for and allocation of additional resources for AIDS, TB and malaria would be in some relative proportion to their respective needs" (Macro International 2009: 11).

¹⁶⁹ The *HIV/AIDS National Strategic Plan* suggests that Uganda has entered the third phase of its HIV/AIDS epidemic. Whereby phase one was signified by rapidly rising prevalence rates, which peaked around 1992, phase two (1992-2000) saw those rates decline. The third phase of the epidemic (since 2000) has so far been characterised by a stabilisation in prevalence rates, although there's increasing anecdotal evidence to suggest that there has been an increase in recent years (UAC 2007).

success story, it would be a worrying indictment of aid - and the GHIs in particular - should Uganda now lose (or see reversed) the gains it has amassed since 1986.¹⁷⁰

The change in the country's HIV/AIDS epidemic coincides with an uncomfortable development in Uganda: the emergence of the questionably aligned PEPFAR initiative as the more reliable of the country's two HIV/AIDS GHIs (in terms of annual funding).¹⁷¹ Helped in no small part by the spate of GFATM disbursement delays and application failures addressed in this chapter.¹⁷² The situation is such that the GFATM was forced to issue Uganda with US \$4.2 million for the emergency purchase of antiretroviral drugs in 2009, after the country came close to suffering a total stock out (Wasswa 2009).¹⁷³ The obvious question therefore is how has it come to this - Uganda having to appeal to the GFATM for emergency funding? Where has the Fund's vision to prioritise needs over quality-based proposals in the round system gone awry?

Disappointingly, it seems that the GFATM, just like the traditional donor model it once aspired to avoid, has become overtly risk averse (indeed more so), prioritising the need for an airtight proposal (in order to guarantee micro-accountability) over the needs of the applicant country. In the current scenario, the countries in the greatest need are often the countries least equipped to access funding. Of course the signs were there at the beginning, when the Fund opted to emulate Global Alliance for Vaccines and Immunisation and become a performance-based funding mechanism. Even so, it appears that the GFATM has grown distrustful of even that safety net,

¹⁷⁰ When the NRM first championed the issue. Please see context chapter for further elucidation.

¹⁷¹ A PEPFAR study suggested that the lack of evidence base for budget allocations and rationale linking the allocations to performance, were undermining the ability of the GHI to harmonise and align (IOM 2007: 99).

¹⁷² Officially PEPFAR money should be the least predictable of the GHI funding initiatives as the US Congress approves funding on an annual basis. In practice however, Uganda has been receiving escalating volumes of PEPFAR funds each year since FY2004.

<http://www.pepfar.gov/countries/uganda/index.htm> [Accessed 15/05/10]

Indeed, the comparative predictability of the PEPFAR funds (even though they are not well aligned due to Congressional earmarking) may go some way to explaining the comment that the GFATM: "It's not worth it" made by a MoH official in this chapter (Interview 16th April 2008). In short, Uganda is relatively confident that the PEPFAR funds will keep coming.

¹⁷³ Dwindling ARV stocks in Uganda were attributed to a combination of factors: a successful testing policy, policy changes that increased the number of people eligible for the treatment and the global financial crisis. Please note that Uganda had actually asked the GFATM for \$8million in emergency funding in 2009, but was only granted \$4.2million (Wasswa 2009).

with the rounds-based application process now so cumbersome that countries aren't consistently being given the chance to 'perform' or 'fail' later down the road. Here, the suggestion isn't that the GFATM should simply throw caution to the wind and lend to any country that applies, after all "All aid donors...have an obligation to ensure that the funds they provide are used for the purpose intended, and that they are utilized as efficiently as possible." (Riddell 2007: 235) The issue is that the Fund should by now have devised a means of managing risk.

The *Five-Year Evaluation of the GFATM* points to failure of the Fund to effectively manage risk, finding that "The lack of a robust risk management strategy during its first five years of operation has lessened the Global Fund's organization efficiencies and weakened certain conditions for the effectiveness of its investment model" (Macro International 2009: 44). Indeed business theory dictates that risk isn't a thing to be avoided but something to be managed, and it was in this vein, that an earlier study of the GFATM suggested applicant countries be risk assessed and categorised according to the results, so that "processes can be streamlined for lower risk grants, while more resources can be allocated to those deemed to be higher risk" (Booz Allen Hamilton 2007: 8). Yet this hasn't happened.

The Fund's inability to manage risk is indicative of the drive for managerialism in development (Mosse 2005) whereby micro-accountability and transparency are touted as the antidote to politically-driven aid. The unplanned consequence of the donor efficiency drive and attempts to make decision-making more visible has been the bureaucratisation of development (also labeled "governmentality" by Ferguson (1990: 64)), the burden for which falls most heavily on the shoulders of the aid recipients.

The twists and turns of the Ugandan case study exemplify how the GFATM's aversion to risk has impacted on the members of Uganda's Health and HIV/AIDS partnerships individually and collectively by forcing them to engage in a complex and burdensome application process which seeks to convince the Fund that the risk involved in giving to Uganda – which did admittedly burn the Fund in the past – has

been mitigated. In the current scenario, it is the GFATM's in country 'partners' who are asked to absorb most of the risk which, on a sliding scale starts with the financial and operational expense of devising the proposal, moves onto the financial outlay involved in contributing to the pot of an aid instrument in regular policy flux, increases to see organizations and coordination forums embark on potentially damaging deviations from their core mandates, and culminates in a government risking its sector-wide focus in pursuit of 'big three' funding.¹⁷⁴

Conclusion

Despite the costs associated with producing a GFATM proposal it is sobering to learn that over the course of nine funding rounds just 42% of submissions have been approved.¹⁷⁵ Furthermore, that the GFATM is currently living from hand-to-mouth in terms of available financing (for Round 9 it was found to have approved more applications than it presently had the funding to serve).¹⁷⁶ And yet the system continues to be skewed in favour of the aid instrument and to the countries' detriment. Shakow for instance has pointed out that almost all the burden involved in the GFATM transaction is placed on the recipients "in this performance-based, country-driven system" (Shakow 2006: 21).

To place the current scenario into context, one needs to impress that prior to the inception of the GFATM, countries such as Uganda would have received HIV/AIDS, Tuberculosis and Malaria monies as a matter course, through un-pooled arrangement

¹⁷⁴ With regards to the use of country forums as the CCM for the GFATM, Chapter Four of this thesis also touches on the issue of risk avoidance in the Fund, highlighting its strategy of including CSOs as mandated CCM members. This plays on the oft-cited argument that CSOs are well suited to the role of government watchdog.

¹⁷⁵ GFATM observer NGO Aidspan has calculated the percentage of proposals approved in each funding round; their results are as follows: Round 1: 28%; Round 2: 43%; Round 3: 39%; Round 4: 40%; Round 5: 31%; Round 6: 43%; Round 7: 49%; Round 8: 54%; Round 9: 53% (Aidspan 2009b). The average rate of approvals over the 9 rounds therefore is 42.2%

¹⁷⁶ GFATM observer NGO Aidspan notes that for Round 9 "the Fund does not currently have enough money to pay for the Round 9 proposals that were rated Category 2B by the TRP. However, the Fund is solidly confident that it will have sufficient funding for these proposals by some point in 2010" (Aidspan 2009b).

from their bilateral and multilateral donors.¹⁷⁷ So while of course the pre-GFATM set-up would have been extremely arduous for the recipient country – with the government having to report to multiple donors to account for multiple funding pots – the key difference then was that its efforts were being expended on monies already flowing. In the original *Framework Document* (GFATM 2002), the Fund was conceptualised as a rapid disbursement instrument, intended to harmonise aid inputs and reduce the bureaucratic burden in countries that could demonstrate a tangible need. The reality however, has been *more* bureaucracy in pursuit of an uncertain reward. The donor frustration and expenditures alluded to in this chapter impress that donor agencies on the ground still want Uganda to access the money. It is after all *their* money.¹⁷⁸ But the GFATM's convoluted application process has become a stumbling block to the country accessing it.

In Uganda, it has been the coordination architecture underpinning the Health and HIV/AIDS partnership that has borne the brunt as a result of the GFATM's deviation from a needs-based approach. It is these foundations – which thanks to the input of Uganda's Development Partners enjoy financial and technical underpinnings - that have been forced to bend and sway in accordance with the Fund's *current* (yet intransigent) demands. Whether this will prove to be to Uganda's credit or detriment remains to be seen.

Remarkably, a lot of what the GFATM has asked for in Uganda has been framed in terms of 'participation'. As such every stakeholder voice must be represented in country proposals and on the CCM regardless of the financial and opportunity costs incurred and the unfeasibility of reconciling countless special interest concerns. My argument however, is that the GFATM has never really enjoyed that clear an idea of what it wants, at least beyond checks and balances to ensure it can account to *its* donors. Participation and coordination therefore are really the means to an end – providing new checks and balances in the form of ever more stakeholder interest to facilitate the continuation of funding - rather than the ends themselves. Moreover,

¹⁷⁷ The professed additionality of GFATM funding remains open to debate. Refer back to footnote no. 110 for a recap on the key points in this debate.

¹⁷⁸ Here, I would refer you to back to sub-section 'The Donor Perspective' in this Chapter.

even these might prove to be but a short stop on the road to somewhere else. Just as the NSAs now threaten to replace the GFATM's funding rounds, who knows whether broad stakeholder participation will survive the GFATM's next remodelling? Maybe a GFATM country presence is the next logical step.

Of course the true irony of the current situation is the GFATM, thanks to the maligned version of the partnership model it has staked its reputation upon, has put itself at the greatest risk of all – threatening its long-term sustainability. This is the warning presented in the *Five-Year Evaluation of the GFATM*:

“A loss of partner and donor confidence can occur if the Global Fund's organizational reputation were to diminish because of poor financial management, or because of ineffectiveness of the grants, or inefficiency in the organizational processes, thereby reducing its comparative advantage in the health development architecture” (Macro International 2009: 46).

The situation in Uganda where the Fund has become a source of criticism – “\$60 million of nuisance” (Interview 9th May 2008) - and exasperation – “it's not worth it” (Interview 16th April 2008) - shows that this is a very real risk that needs to be addressed if the country's health and HIV/AIDS stakeholders aren't to withdraw their participation from the Fund's “large-scale experiment” (Oomman *et al.* 2007: 3). More seriously however, the risk presented by entrusting Uganda with life saving funds needs to be re-conceptualised by the GFATM Secretariat and offset against the more sober risk posed by withholding them.

CHAPTER SIX:

COORDINATION TO BUILD POLICY CONSENSUS AS AN ACT OF LEGITIMISATION

Introduction

In this chapter I forward the proposition that with aid conditionality out of favour, several of Uganda's Health Development partners are attempting to use 'coordination' techniques to build consensus around their own development objectives. In this way policy actually follows practice (Mosse 2005) as creating consensus only serves to legitimise what development partners are already doing in the health sector. Indeed a failure to build consensus need not create the impetus to change agency policy, particularly if what you are doing is found to be effective. Instead it is likely that more consensus building/coordination is what is really required.

Mosse (2004, 2005) set out to challenge the conventional view that practice follows policy by posing a very simple question, namely what does policy do? In my own work, I have tried to ask a similar question of 'coordination'. Asking what does coordination *do*? And what might be the value of that action? In this chapter, I am guided by Mosse once again, taking as my starting point his proposition "that policy primarily functions to mobilize and maintain political support, that is to legitimise rather than to orientate practice" (Mosse 2004: 648; also see Apthorpe 1997).¹⁷⁹ For it was only once I had internalised the legitimising effects of policy, that I was able to make sense of the behaviours I witnessed amongst Uganda's Health Development Partners as they sought to build policy consensus around their own development objectives using coordination techniques.¹⁸⁰ To understand why development

¹⁷⁹ In a related vein, Apthorpe (1997) has suggested that policy aims to persuade rather than to inform.

¹⁸⁰ Walt *et al.* suggest "It would appear that interest in coordination is inextricably linked with influence and that coordination tools, and particularly leadership therein, provide the potential to enhance leverage over policy direction or resource mobilisation" (Walt *et al.* 1999: 215; see Brown *et al.* 1998 and Buse 1999 as case examples).

partners working in Uganda's health sector may now need to be legitimised through policy, it is necessary first to underscore the new competitiveness in development, as introduced by the Paris Declaration.

Where once Easterly's (2002) "cartel of good intentions" rang true (which suggested that donors would never criticise one another for fear of drawing fire on themselves), the Paris Declaration has held up a yardstick to the actors in development and provided them with a purpose-built vocabulary by which to judge one another (e.g. "your aid is aligned but your activities are not well harmonised").¹⁸¹ Moreover, just as certain aspects of the Paris Declaration – 'alignment', 'harmonisation', 'ownership' – now reward development partners when they engage in what would once have been termed political lobbying (now read 'coordination' activities), other Paris stipulations – to undertake division of labour exercises and exit sectors where you don't demonstrate comparative advantage – are actively threatening livelihoods. For partners serious about their Paris commitments therefore, the struggle is to remain relevant in your sectors (and in your host countries), whether this be through policy input, financial contribution or both. The following quote from SIDA's health representative for Uganda attests to the pressures at work:

"SIDA is following the Paris Declaration like its own Constitution, really taking it ad verbatim as you say. It has meant that we have lost health in a number of countries. So right now we actually only have bilateral health support in Uganda and Zambia. And well Mali and Burkina Faso but that's delegate - you know silent partnerships...we are there in terms of funding but not in terms of anything else. So it's Uganda and Zambia. So everybody has agreed, and also the Swedish government, that with these two countries – we're in health in these two countries – now we really have to put in a lot more effort and being [Sector] Lead would just really reflect that we're serious, we're going to stay here, and really feel like we can do a lot" (SIDA Interview 22nd May 2008).

The key points of the SIDA tale - being reduced to two health sectors, under immense pressure to show comparative advantage and win Sector Lead in the division of labour exercise in Uganda - raises the spectre of something unimaginable

¹⁸¹ In Uganda, an evaluation on the implementation suggested that Paris had: "provided a basis for DPs to compare themselves with others..." (Office of the Prime Minister 2008: 19).

pre-Paris: donors without recipients. By which I mean, aid donors who have lost their mandate to have a say in the national policy of aid-recipient countries, which over time could erode the broader case for giving aid to that country. Of course, such a threat only applies to donors who demonstrate a serious commitment to the tenets of Paris (i.e. the school of donors who derive some legitimisation from playing by the rules). Nevertheless, post-Paris, this once implausible threat exists.

Furthermore, it's important to appreciate that the pressures now bearing down on the aid architecture transcend donor organisations. Comparative advantage, added value and a demonstrable influence in policymaking are just some of the criterion used now for the allocation of public funds. It is not only aid flows at threat in the aid architecture therefore, but organisational *raison d'être*s. The inclusion of a WHO case study in this chapter attests to this point.

Therefore, while this chapter is first and foremost concerned with explaining the coordination techniques Health Development Partners are employing to build consensus around policy objectives in Uganda's health sector, such efforts need to be viewed against the backdrop of a competitive aid system, and the legitimising effects of policymaking.

I will introduce the case material forthwith. First however, it may be useful to posit: when and why did policy get to be so important in development?

The New Aid Orthodoxy: Getting Policy Right

In the introduction to this thesis, I alluded to the apparent fluidity and interchangeability of the terms that epitomise the modern development vocabulary (Mosse has termed them “master metaphors” (Mosse 2005: 9)). In this chapter, it is the increasingly difficult relationship that exists between the terminology of ‘coordination’ and ‘ownership’ when implementing the modern aid partnership that is drawn out by the case studies. The problems identified derive from the somewhat

incongruous proposition that accompanies the joint usage of these terms: that a nation state - in which an increasing number of external partners demand a seat at the policy table - can claim 'ownership' of the policies developed through multi-stakeholder consultation. Aside from the obvious dilemma this proposition poses for the sovereignty of the nation state/aid recipient (Okunzi and Macrae: 1995), I would also stress the conundrum this development imperative poses for the aid donor, namely: how to advance individual agency objectives during the era of aid effectiveness with its emphasis on fostering equitable partnerships? It is this conundrum that underpins the second utility I shall argue accompanies coordination activities in Uganda's health sector: an attempt to further donor policy objectives through consensus building.

In their 1995 article, "Whose Policy is it Anyway?" Okunzi and Macrae draw on two case studies to suggest how aid conditionality has at times been used to buy policy in Uganda's health sector. The background to the article was that following decades of instability in Uganda - and the resultant policy vacuum - donors had become accustomed to initiating large vertical projects without any interference from the state. However, this unfettered dominance was challenged in the 1990s when the new NRM government devised the first strategic plan for the health sector: the *National Health Plan* (MoH 1989). Fundamentally unhappy with what would now be conceived of as a nationally *owned* plan, Okunzi and Macrae underline how "getting 'policy' rather than 'project' right" suddenly became a major concern for Uganda's major health donors who sought to amend the national strategy using their official development assistance as leverage (Okunzi & Macrae 1995: 130). A key instrument they employed at this time was aid conditionality. I shall return to how this was achieved by Nordic donor Danida in due course (in a bid to explaining its current dealings in the sector); for now however, it is important to note that in the new millennium, with *overt* aid conditionality and project aid - i.e. the traditional donor tools for manipulating and/or circumventing state decisions - distinctly out of favour, donors' aspiration to "get policy right" is stronger than ever. I shall argue that consensus building is one key technique being attempted to achieve this.

To underline the central connection between consensus building as a method for amending policy and the logic of ‘ownership’ - as both an ethos of the new aid agenda and a measured target of the Paris Declaration - it is significant that back in 1994, a study by Foltz had already underlined the importance of national ownership to the success of any policy in which aid donors shared a vested interest. In her opinion, the host government’s perception of ownership was crucial to a policy’s sustainability on three levels: to ensure reform was adopted in the first place, to increase the likelihood that the host government would be willing to contribute financially to the policy’s implementation (i.e. securing its financial sustainability), and to increase the likelihood that the policy would be implemented by national institutions as opposed to parallel management units (i.e. aiding the policy’s longevity by simultaneously building national capacity). In short, despite writing her article during a period when aid conditionality was still very much en vogue, Foltz’s insight into the factors which contribute to the long-term sustainability of a policy were already undermining the capacity of aid conditionality to achieve long-term policy change if the national government was not on board with the changes. It is this proposition: that aid can’t in itself buy sustained policy change in an aid recipient country, which provides the foundation of the argument forwarded in this chapter.¹⁸²

The second component of my argument takes this understanding one step further: it acknowledges that, in line with the aid effectiveness directives of the new millennium, most donors now don’t even have the tool of aid conditionality at their disposal (i.e. the leverage to force a policy into existence), and as such, need to create a sense of national ownership around policy just to get it off the ground. Finally - and to complicate matters further – my stance also recognises that a recent proliferation in the number of actors demanding a say in policy discussions at the central level in Uganda means there are now more voices than ever – each with their own interpretation of what it means to “get policy right” - competing for the government’s ear regarding health.¹⁸³ The consequence of all these factors acting together is that

¹⁸² This argument is further substantiated by the Burnside and Dollar (1997) argument that aid can’t buy policy in a bad policy environment.

¹⁸³ In Chapter Seven I discuss the inclusion of civil society to the Health Policy Advisory Committee in Uganda at the bequest of the GFATM.

the need to build consensus around policy initiatives is now a fundamental requirement for all partners wanting to further their individual concerns in country. Or to frame it another way: Uganda's Health Development Partners are now having to convince the Ugandan Government and one another that their interests are in everyone's interest.

Remarkably, Okuonzi and Macrae had already predicted this need for change in the aid relationship back in 1995 when they underlined the fatal flaws in using aid conditionality for policy change (for sustainability, accountability and sovereignty). Their recommendation at this time was that "The situation has heightened the need for policy partnerships between international and national actors, rather than the politics of domination which currently predominates" (Okuonzi & Macrae 1995: 131). As such, they were of the opinion that while donors – and other actors – did have a valuable contribution to make to policy discussions in Uganda, the national ownership of policy changes had to be made paramount. Their tacit suggestion was that donors would be better off building coalitions and supporting national fora for debate and discussion rather than continuing to throw their weight around in the partner country.

In this chapter I intend to demonstrate how three of Uganda's Health Development Partners (HDPs) are undertaking the recommendation to revise the traditional aid relationship and attempting to build policy consensus in Uganda's health sector through coordination measures. In doing so, I will focus on three very different organisations – Danida, the World Health Organisation and USAID – in a concerted effort to expose the different manifestations of this change, while nevertheless underlining the discreet value still attached to aid flows within the health partnership. Moreover, in recognition of Foltz's stance regarding ownership as a prerequisite for the sustainability of policy, the underlying question I will level against each of the case studies organisations will be: has the complication of having to instil national ownership in policy prescriptions been resolved by any of these HDPs, and if so, by what means?

I turn first to Nordic donor, Danida.

Danida, Essential Medicines and Wearing “Two Hats” in the Health Sector

Out of the three case studies I shall present in this chapter, Danida’s position in Uganda’s health sector is the most striking for three reasons. Firstly, for the radical transformation of its partnership with the Government of Uganda over a twenty year period whereby it has gone from operating in parallel to the state, to offering aid with strict conditionalities, to championing Uganda’s national systems and policies. Secondly, for the unique *modus operandi* of its in-country team, whereby a sub-section of the Danida health team physically sits at Uganda’s Ministry of Health. Thirdly, for the pragmatic and innovative approach its field staff take to implementing a donor programme that (as they recognise) fully exemplifies the contradictory nature of the modern aid effectiveness agenda - asking them to combine partnership with policing at the country level - which they do by assigning their government counterparts at the Ministry meaningful lines of accountability.

I shall introduce each of these issues in turn, beginning with the evolution of the Danida-GoU partnership. Here I employ a study of Danida’s key involvement in Uganda’s essential medicines programme as a backdrop.

As the *Danida Health Sector Programme Support Phase III* (HSPS III) document attests, “Danida has a strong history of supporting the Pharmaceutical Sector in Uganda in policy development, institutional development and the development of sustainable purchasing storage and medicine distribution systems” (Danida 2005: 43). Indeed, it is this long standing interest in Uganda’s medical supply chain that Okuonzi and Macrae chose as a focus of their 1995 study, in which they identified certain programmatic areas where aid conditionality had been used to buy policy reform in Uganda’s health sector. To provide a brief synopsis of the Okuonzi and Macrae argument with regards to the Danida case study: they noted that the 1985

Uganda Essential Drugs Management Programme (UEDMP) was facilitated through assistance provided by Danida and the Danish Red Cross; and that despite being initially conceived of as an emergency programme, the UEDMP quickly evolved to become the main source of drugs and medical equipment for the whole of Uganda. When the first phase of the UEDMP ended in 1990, Danida offered to finance a second ten-year phase of the programme, but crucially at this point, with certain conditions attached.¹⁸⁴ These sparked opposition from both the local authorities and the national press who accused Danida of trying to monopolise Uganda's drug supply and to tie aid for essential medical supplies to Danish suppliers. In response, Danida issued an ultimatum to the Government of Uganda: enact its policy recommendations or see the Essential Drugs Programme cease. Thus when in 1993, the Drug Policy and Authority Bill - that Danida was backing - had still not been tabled for review, the donor finally flexed its muscle, cutting Uganda's drug supply by two-thirds. Yet this show of strength notwithstanding, the Drug Policy and Authority Bill was rejected at its first reading in May 1993, and only pushed through on its second reading – following several amendments - later that year.

Now clearly the narrative of a Danida that employs aid conditionality to force through policy objectives sits at odds with the popular perception of it today as one of the world's most progressive bilateral donors. Yet two points stand out from the Okuonzi and Macrae case study: firstly that Danida's initial involvement in Uganda's pharmaceutical sector had been while in emergency/humanitarian project mode; and secondly, that despite its brief foray into the politics of domination, Danida had nevertheless failed to unilaterally impose its will on a resolute Ugandan government.

To put the events of that time into perspective, it is apparent that Danida had monopolised debate and activities surrounding essential medicines in Uganda for long enough to think that it alone knew the best prescription for Uganda's future

¹⁸⁴ 1. Enact a new drug policy providing laws for the manufacture, procurement, distribution, marketing, storage and quality control of drugs. 2. Only allow drugs approved by the government to enter the country. 3. Set up a national drug authority to oversee drug importation, manufacture and distribution. 4. Make the Central Medical stores autonomous from the MoH and place it under Danida administration; rename it National Medical Stores (NMS) and allow it to sell drugs to government, non-government and private facilities; make NMS the only agency responsible for the procurement and importation of drugs into the country (Okuonzi & Macrae 1995: 128).

procurement arrangements. However, it had underestimated the growing confidence of the NRM government in the 1990s to challenge its position. Indeed, this first part of the Danida narrative exemplifies the steep learning curve faced by every donor who has opted to make the move from project to programme mode in recent years: accompanying this new foreign policy direction will have come the revelation that whether it's done passively (as in this case when there was a delay in the Drug and Authority Bill being tabled) or actively (as in this case when the Bill was outright rejected), the recipients of development aid are now empowered to delay and/or reject, to accept and/or subvert the recommendations of the aid givers. It is this understanding that underpins the rhetoric of 'partnership' and 'ownership' characterising the new aid agenda.

Turning now to look at the contemporary Danida pharmaceutical programme in Uganda, I would posit that the donor agency has at some point made the connection between policy and ownership since its negative involvement with the 1993 Drug and Authority Bill. In a very literal pursuit of partnership, Danida has situated a team of full-time advisors at Uganda's Ministry of Health (known as the HSPS III Support Unit).¹⁸⁵ I shall expand on this unusual *modus operandi* in due course. Now however, I shall concentrate on just one of its team members: the Medicines Management Advisor. This appointment epitomises the revised partnership model favoured by Danida Uganda in the new millennium.

The Medicines Management Advisor is a full-time position that physically situates a Danida technical advisor within the MoH pharmaceutical team to assist with the implementation of Component Five - pharmaceutical sector support- of *Danida's Health Sector Programme Support Phase III (HSPS III) to Uganda's Health Sector*

¹⁸⁵ The HSPS III Support Unit at Uganda's Ministry of Health is comprised of four technical advisors - a Senior Technical Advisor (the unit manager), a Public Health Advisor, a Financial Advisor and a Medicines Management Advisor – and their administrative support. This Unit is overseen by the HSPS III Coordinator at the Danish Embassy. The HSPS III programme document states that: "It is absolutely critical that the functions of the HSPS Coordinator be separated from the functions of the Senior Technical Advisor because the latter is part of the MoH organizational structure and will not be in a position to monitor the implementation of HSPS II and HSPS III" (Danida 2005: 77).

Strategic Plan Phase II (HSSP II) (Danida 2005).¹⁸⁶ The job description for the position states that, “The Medicines Management Advisor will be attached to MoH Headquarters in order to provide support for technical and management capacity-building in the provision of essential medicines...” (Danida 2005: 114). As such, the planned outputs of Component Five – which includes such targets as “MoH able to fund essential cost-effective medicines and health supplies...” and “Department of Pharmaceutical Services and Health Supplies established and functioning” (Danida 2005: 67) - are for the most part designed to be fulfilled by, and attributable to the Ministry rather than the donor. Indeed, a key point to stress about Danida’s pharmaceutical component – and the broader *HSPS III* - is that it has been designed within the existing policy and strategic framework governing Uganda’s health sector, and thus neatly fulfils the Paris objective of ‘alignment’.¹⁸⁷ In this way, the MoH should emerge both as a beneficiary of the Advisor’s appointment, and as the protagonist in the partnership. Indeed, according to the national framework for the health sector, Danida’s Medicines Management Advisor shouldn’t even (in theory) have any more input into policy discussion than any other HDP in the sector, in spite of his physical advantage.¹⁸⁸ Instead he should be adding value at the MoH by virtue of his unique vantage point and skills set; the latter of which he should of course be disseminating to the national team. In short, the real value of the Danida Medicines Management Advisor should be to help the MoH operationalise Uganda’s *existing* policy objectives in the pharmaceutical sector in the critical ways that contribute to their sustainability: by increasing national capacity and by fostering ownership. This makes sense considering Uganda’s health sector is no longer operating in the policy vacuum that characterised it in the 1980s. Instead it is currently typified by a plethora of policy objectives still to be funded and operationalised.¹⁸⁹

¹⁸⁶ Danida’s HSPS III contains 5 components: 1) Support to district health services, 2) Support to the districts in the north, 3) Central-level support to MoH, 4) Support to training enrolled comprehensive nurses, 5) Pharmaceutical sector support (Danida 2005).

¹⁸⁷ HSPS III was designed within the framework of Uganda’s PEAP, HSSP II, NHP, SWAp and MoU (Danida 2005: cover page).

¹⁸⁸ For the Pharmaceutical sector, discussion to feed into policy will occur in the Medicines and Procurement Technical Working Group. A multi-stakeholder forum, this working group will provide the technical basis of policy recommendations made further up the chain, at the Health Policy Advisory Committee. See Appendix 2 outlining the health sector’s organisational structure.

¹⁸⁹ Excerpt from the *Annual Health Sector Performance Report FY 2006/07*: “At the current level of funding, HSSP II is only 42% funded based on the best estimate scenario and 65% funded at the constrained resource envelope scenario” (MoH 2007a: 83).

Having said all that, it would be naive to suggest that the Danida Support Unit at the MoH is totally disinterested in influencing outcomes in this programmatic area, especially given the volume of funding the donor has assigned to it. Indeed, as a proportion of the HSPS III budget, the pharmaceutical component is the most important: at 42.5% of the total (Danida 2005: 102). Moreover, the funding Danida has pledged to provide to Uganda's Essential Medicine Credit Line (EMCL) over the duration of HSPS III distinguishes it as the donor's single biggest spend in the health sector - even surpassing the volume it has assigned to sector budget support/Poverty Action Fund funding.¹⁹⁰ Finally, the significance of funding to the EMCL is increased again considering that, unlike other facets of the health budget – which are managed by the Support Unit in Uganda – EMCL money is one stream of Danida's health budget to go directly into the MoH's purse.¹⁹¹

The Essential Medicines Credit Line is a basket funding mechanism co-financed by Danida and the Government of Uganda to pay for essential cost-effective medicines and health supplies.¹⁹² A rudimentary explanation of how it works is that each of Uganda's districts is allocated a proportion of money – a credit line - with which to buy drugs from a predetermined shopping list at the National Medical Stores.¹⁹³ This gives the districts (Uganda's healthcare providers) the autonomy to buy medicines according to their particular needs, as opposed to having the centre make blanket decisions on their behalf. How Danida retains some influence over this delegated basket modality is as a direct result of the country team's peculiar *modus operandi*, which sees its advisors undertaking targeted capacity building activities at the MoH. To provide two literal examples, out of the activities listed to be undertaken by the

¹⁹⁰ The grand total of the pledged funding for five years of HSPS III is 416,200. Within this, the total pledged to the Essential Medicine Credit Line is 100,000 while the total pledged to the PAF is 90,000 (budget figures are given in Danish krone '000) (Danida 2005: 102).

¹⁹¹ PAF money is also different as it goes directly to the Ministry of Finance. Everything else in the Danida budget is channelled through the HSPS II Support Unit (i.e. the Danida health team on the ground in Uganda).

¹⁹² Because the GoU will draw on PAF money to finance its share of the EMCL, other HDPs will be indirectly contributing to this basket fund. What marks Danida out is that it supplies PAF money and direct funding to the EMCL. See box 1, p23-24 for an explanation of basket funding.

¹⁹³ Private not-for-profit health providers (who deliver 30% of Uganda's health care and receive a government subsidy) have a similar set up whereby they can use credit line money to buy essential medicines from their supplier, Joint Medical Stores.

Medicines Advisor at the MoH, activity four is “Support the further development of resource-based planning and allocation strategies for the sustainable provision of cost-effective medicines and health supplies...” (Danida 2005: 67).

Remarkably, one of the initiatives currently being undertaken at the MoH – with Danida (and WHO) technical support – is the development of *The 3-Year Rolling Procurement Plan for Essential Medicines and Health Supplies* (MoH 2007c). The purpose of this plan will be to quantify every input into the health sector – including parallel donor procurements – and to strive to align these inputs with quantified needs. The *Rolling Plan* is a nationally driven initiative, developed by the pharmaceutical division at the MoH (Interview 9th May 2009). Yet as one can see, it fits in nicely with the activity assigned to the Danida Advisor above, and as such can benefit from his technical input. Moreover, because Danida as a donor is a key player in coordination activities within the health sector, the broader Danida country team are also in a key position to promote the Plan in coordination forums - such as the Medicines and Procurement Technical Working Group, the HDP Group and the HPAC – using in those instances their diplomatic influence to highlight the problems of over and under funding that continue to accompany unaligned donor inputs to the sector.¹⁹⁴ In this way, the *Rolling Plan* contains the potential to make the money that Danida contributes to the EMCL more effective and more efficient in the long-term by reducing waste and duplication across the sector.

Moving on, another of the listed activities to be undertaken by the Medicines Advisor at the MoH with regards to the EMCL is as follows:

“Continue support to the management of the Essential Medicines Account at MoH, including development and operation of the required information, reporting, accountability, and tracking systems through MoH through NMS and JMS [Joint Medical Stores] to end-users” (Danida 2005: 67).

¹⁹⁴ At the PEPFAR’s Uganda’s Dissemination and Stakeholders’ Consultation held in Kampala on 3rd May 2007, I witnessed the Danida HSPS III Coordinator use a break out session to raise awareness about the *3-Year Rolling Procurement Plan for Essential Medicines and Health Supplies*. Her doggedness saw the Rolling Plan being recorded as a priority focus for PEPFAR FY08.

If one fully considers the implications of this activity, one can see that Danida Uganda has devised a very subtle way of subverting the traditional donor model of micro- managing its funds, and in a manner that serves to tick off all the boxes of the Paris definition of “harmonisation.” As such, instead of independently accounting for every penny of Danida funding to the EMCL in a parallel mechanism, the Medicines Management Advisor and the HSPS Senior Advisor are actually in place to assist the MoH create accountability for its “own” basket fund. This is underscored by the fact that Danida doesn’t maintain any parallel indicators in the health sector, thus encouraging the MoH to strengthen the national Health Management Information System and to improve its own capacity to analyse data. That is not to say of course that the Danida team does not check the MoH’s figures (aside from the oversight of the Danida advisors at the Ministry, all of the HSPS III accounts are subject to annual external audit) but as one WHO commentator said of the Danida working model in Uganda’s pharmaceutical sector, it can be summed up by the phrase “hands off but eyes on” (WHO Interview 8th November 2007).

To continue in the vein of accountability, it was interesting that the Senior Advisor of the MoH-based Danida Support Unit (who is also the Support Unit manager) repeatedly hinted at a direct connection between the concepts of “accountability” and “ownership” when talking about the team’s changing *modus operandi* at the MoH.¹⁹⁵ To provide a key example, the Senior Advisor explained how the Support Unit had decided to revise the manner in which they were managing funds allocated to programme Component Two - support to the districts in the North. While previously the Support Unit had maintained a purse of money at the centre, out of which northern districts could appeal individually for a share, the HSPS team opted to emulate the credit line system they’d developed for essential medicines, except to fund essential medical equipment for all of Uganda’s districts. The result is a second basket fund, “owned and operated” by the MoH, and with two additional contributors, the GoU and the United Nations Population Fund.¹⁹⁶ The true value of

¹⁹⁵ He has been in the current position for approximately 3 years.

¹⁹⁶ To expand the programme and make it country wide, Danida also convinced the GoU and UNFPA to contribute to the basket.

the fund however, is again derived from the empowerment of the districts to determine their own needs. As the Senior Advisor explained:

“You have donors who sit in New York or Copenhagen, or wherever it may be, or people sitting here deciding what the districts need instead of you know, saying: ‘This is your money’...Let them be the ones to make their own mistakes, instead of us making mistakes like we always do” (Danida Interview 7th May 2008).

This reasoning provides a fairly compelling argument for one means through which ownership might be fostered within the aid relationship. Indeed it’s interesting to underline how much the *modus operandi* of the HSPS III team has altered in the last few years to embrace the simple logic that “they have ordered themselves, they were involved in the process, its their resources...[the hope is] it would be more effective” (Interview 7th May 2008). In particular, the Senior Advisor seems to have played an integral role in completely overhauling the Danida country model, having been struck on arrival by the inconsistencies between the rhetoric and reality of Danida’s partnership in country. Notably, the biggest thing he had a problem with was the illusory structure of accountability the HSPS III was imposing on the MoH.

While accountability for the entire HSPS III programme had originally been attributed to designated persons within the higher echelons of the MoH, the Senior Advisor immediately recognised that there were whole swathes of the Danida programme over which those staff had no mandate.¹⁹⁷ To provide some examples: for Component One - PAF support - whereby the money goes straight to the Ministry of Finance, the MoH has no mandate; for Component Two - support to districts in the north - whereby the money was originally allocated via the Support Unit (in the pre-credit line arrangement), the MoH had no mandate; for Component Three - central-level support to the MoH - accountability for money entering every division of the Ministry had been assigned to the Director of Planning, who had no mandate for funding outside his own department; and finally, Component Four – support to the training of enrolled comprehensive nurses in the private not-for-profit schools -

¹⁹⁷ The Permanent Secretary and the Director of Planning at the MoH were assigned unworkable lines of accountability in the earlier Danida set up. The HSPS III model has now been redesigned to delegate meaningful responsibilities (Danida Interview 7th May 2008).

had literally nothing to do with the Ministry at all, neither had certain aspects of Component Five, support to the pharmaceutical sector.¹⁹⁸

The reason this unfair and unenforceable chain of accountability for the Danida health programme had gone unchallenged for so long was because previous incarnations of the MoH Support Unit had been operating as a traditional expatriate donor support team - actively micro-managing every penny of the budget, and allocating neither money nor responsibility to the MoH. This contradiction is exposed if you refer back to the *HSPS III* programme document, which explains in laborious detail how the Support Unit – and not the MoH - would achieve accountability for Danida’s budget.¹⁹⁹ The Senior Advisor sums up the role he was originally recruited to play as follows, “You are having two hats on”, that of: “technical advisor” and “policeman” (Danida Interview 7th May 2008).

Given the influence of the ‘good governance’ agenda on the aid partnership in recent years, I would argue that the extolled lines of accountability between the Danida health programme and the MoH were intentionally superficial, yet nevertheless serving a valuable purpose: by providing the semblance/trappings of meaningful partnership while posing little or no risk to the donor. The Senior Advisor said this of the earlier set up:

“This Support Unit was in the past pretty much run as an old donor unit. You know like a lot of donors still have...it was made pretty clear that basically you are supposed to run this show here and make sure that all the money is correctly spent and audited and accounted for...So there’s a certain amount of lip service paid to what is the right thing to say, and then there are other expectations in terms of what you’re supposed to do” (Danida Interview 7th May 2008).

As with the restructuring of the HSPS Component Two budget (to become a credit line for medical equipment), the current HSPS III Support Unit has now completely overhauled the original accountability structures for the programme, trying where

¹⁹⁸ For instance, Danida was providing funding to the Pharmaceutical School at Makerere University.

¹⁹⁹ Every component chapter of the programme document ends with a section entitled “Criteria for provision of support” (Danida 1995).

possible to directly allocate funding and responsibility to the Ministry. In this new mode of working, the Senior Advisor retains a watchful eye over the use of the Danida budget (for instance co-signing on planned expenditures) but has, where feasible, handed over the actual purse strings to the MoH.

Having argued that the delegation of accountability might be one way in which the dilemma of ownership can be resolved in the aid relationship (thus contributing the sustainability of policy), a prerequisite for assigning such responsibility to the aid recipient – as determined by the Senior Advisor - is transparency. In his own words, “In the SWAp process as far as I am concerned, if you don’t have the money, the currency you have to pay back with is transparency...And it goes both ways...I’m not just blaming the government here” (Danida Interview 7th May 2008). In short, if one considers a lot of the behaviours that undermine partnership principles to arise from the risk aversion of donors, then you can begin to understand why the concepts of ‘partnership’ and ‘ownership’ have become much maligned in the aid partnership: meaningful partnership cannot exist without trust.²⁰⁰

The Danida Support Unit has been able to delegate more accountability to the MoH by asking for modes of reporting unprecedented in Uganda’s health sector: they’ve asked the MoH to produce detailed work plans to align their daily activities with the policy objectives contained within the national *Health Sector Strategic Plan II*. In addition they have asked the MoH to account for the expenditures linked to those activities that are directly funded by Danida. Clearly this could be viewed as a new intensity of donor micro-management if it weren’t for the facts that the work plans are not specific to Danida-funded activities (and are instead improving financial planning for all MoH activities), and that Danida is offering up an equal measure of transparency to the MoH.²⁰¹ Danida has now linked HSPS III support with the MoH work plans, and equally accounts to the MoH on the minutiae of where its budget is

²⁰⁰ Chapters Four and Seven deal in more detail with risk aversion and the good governance agenda, which this thesis argues serve to undermine the potential for meaningful coordination/partnership in Uganda’s health sector.

²⁰¹ The MoH work plans aren’t Danida specific but cover the full range of activities the Ministry intends to operationalise in a given financial year. That said Danida’s involvement in capacity building at the Ministry has enabled their development.

being spent in the health sector. Thus whereas a large proportion of donor funds continue to pass through a metaphorical black box, the MoH-Danida partnership has been reinvigorated in recent years by the introduction of mutual accountability.

The final lesson I would draw out of the Danida case study, in order to explain why the relationship between the HSPS Support Unit and the MoH may now prove more conducive to the concept of national ‘ownership’ is to concur with the Walt *et al.* standpoint that “people matter” (Walt *et al.* 1999b: 274). Indeed, what’s interesting about the Danida case study and the innovative manner in which the Support Unit at the MoH has remodelled its relationship with the national health authority is that it so perfectly evokes the Walt *et al.* conclusion that “aid relationships are strongly mediated by particular personnel in country offices and their involvement in the aid process, in both positive and negative directions” (Walt *et al.* 1999b: 276).²⁰² Subsequently, while presenting this case study of Danida’s health programme in Uganda, I would stress that the transitory alchemy of this particular incarnation of the HSPS Support Unit offers little or no insight into Danida’s other relationships around the world. Instead, I would argue that the *modus operandi* currently employed by the Danida Support Unit can only really be explained by the people it currently employs, and in particular by the ethos of the Unit’s Senior Advisor, who was driver behind the delegation of meaningful responsibility at the Ministry, and who explains the reasoning behind that as follows, “I refuse to be part of bypassing the whole thing. We’re here for a few years then we pack up and go home” (Danida Interview 7th May 2008).

I can further exemplify that people (and their vantage points) matter by highlighting the manner in which the interviews at the MoH’s Support Unit exposed differences of opinion between the Support Unit and the Danish Embassy in Kampala, thus evoking a new understanding of the “two hats” analogy - with Support Unit staff dividing their allegiances between the Embassy and the MoH, and impressing on the Embassy that “it’s not our money, it’s basically money belonging to the government” (Danida Interview 7th May 2008). This blurred line of allegiance was best illustrated

²⁰² The idea that “people matter” (Walt *et al.* 1999b: 274) is dealt with in more detail in Chapter Four.

by the Public Health Care Advisor within the Support Unit, who explained that she had been working in the same department at the MoH for ten years (employed for the first five years by the MoH and for the last five by Danida). She described her division of labour as follows: “I would imagine that currently more than 90-95% of my time is just straightforward technical work – it’s not Danida specific” (Danida/MoH Interview 9th May 2008). I would suggest that such extensive integration into the MoH structure – although an extreme model of coordination not suitable for most donor agencies - bodes very positively for the national ‘ownership’ of the Danida health programme.

Danida Case Study Conclusion

Having suggested at the beginning of this discussion that Danida Uganda may be one of the few donor agencies to have successfully made the connection between the concepts of ‘policy’ and ‘ownership’, I have sought to underline the various ways in which the donor has sought to coordinate with the MoH to create a more meaningful partnership. And while I have been determined to impress the Danida ethos of aligning its policy objectives with the country’s own strategic framework, I have hopefully also demonstrated the ways in which the advisory unit at the Ministry is feeding into wider policy debate and (perhaps more importantly) policy implementation at the country level: by building capacity at the MoH, by increasing mutual transparency across the aid partnership, by assigning meaningful lines of accountability at the MoH, and by fully integrating the HSPS III team into the MoH structure.

Moreover, while it hasn’t been a major focus of this discussion, it’s important to underline again the role that the broader Danida health team (including the Embassy division) plays within Uganda’s multi-stakeholder sector forums: the Technical Working Groups, the Health Development Partners Groups and the Health Policy Advisory Committee. This further integration into the coordination fora of the health sector provides alternative technical and diplomatic routes through which Danida – in its function as a Health Development Partner - can attempt to create consensus around its policy objectives. Crucially, the fact that Danida’s programmatic

objectives have been consciously aligned with those of the nation state gives the Danida staff a degree of moral authority not enjoyed by those HDPs championing concerns outside the sector's national strategic framework.

To now consider the facet of the argument that recognises the recent proliferation of actors in the health sector competing for the government's ear regarding policy formation, then one can immediately see the advantage Danida has wrought by its two-tiered approach to sector coordination. In this light, the analogy of "wearing two hats" in the health sector can be translated to mean covering all bases in the pursuit of policy consensus: fostering meaningful partnerships with both the state and the other HDPs in the health sector.

In this section I have argued that there are advantages to Danida's unique approach to coordination measures in Uganda's health sector, and yet logic dictates that it is not a *modus operandi* that Uganda's other development partners could easily emulate. Indeed it would be ridiculous and totally contrary to the ethos of harmonisation if Uganda's other HDPs were to request office space at the MoH. It is a working arrangement particular to Danida's positive reputation in country. The questions then are: what other coordination models are currently on offer to the partners? And are these any more or less conducive to building policy consensus in the health sector.

I turn now to the second case study organisation: the World Health Organisation.

The Changing Remit of the World Health Organisation

In a discussion looking at the potential of consensus building to inform policy in Uganda's health sector, the WHO case study serves as a useful benchmark against which to measure Uganda's other Health Development Partners. There are four reasons for this premise. The first is that unlike donors who may choose to opt in or out of policy debate in the health sector, WHO's set of core functions - notably three

and four (see box 12) - actively mandate it to play a role in national policy debate and development. The second is that while donors still enjoy the luxury of picking and choosing their causes (they can be said to have ‘aligned’ even if their interest only targets a small handful of the sector’s needs), the mandate of the UN’s Specialised Agency for Health dictates its interest be holistic - confined to neither sector nor nation. The third is that as the WHO Country Office (WCO) is not an implementing body, it has to rely predominantly on the national healthcare system to operationalise its recommendations (its budget doesn’t stretch to the long-term funding of civil society organisations) and as such it has to maintain a good working relationship with its government partners. Finally - and of course in relation to all of the above - the important fact that WHO is not a donor means that technical expertise and coordination activities constitute its main bargaining chips in Uganda’s health sector partnership.

Box 12: The Six Core Functions of the World Health Organisation

- 1) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed
- 2) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
- 3) Setting norms and standards and promoting and monitoring their implementation
- 4) Articulating ethical and evidence-based policy options
- 5) Providing technical support, catalysing change, and building sustainable institutional capacity
- 6) Monitoring the health situation and assessing health trends.

Source: <http://www.who.int/about/role/en/index.html> [Accessed 19/02/09]

In short, in a health sector where political manoeuvring can still trump established sector priorities if enough money is put on the table (see the USAID/PEPFAR case study in Chapter Four), the ability of WHO to foster policy consensus in the sector is absolutely essential if it is not to become obsolete. Thus while donors - and even civil society organisations - bring a material advantage to the health partnership in

Uganda, the main currency WHO consistently delivers is technical assistance. The following statement by the WHO Representative for Uganda provides an insight into the pressure that puts his team under, “We have to be on top of everything...that’s our job” (WCO Senior Staff Meeting 10th September 2007). Another telling phrase to emerge during the interviews carried out at the Uganda World Health Organisation Country Office (WCO) centred on the notion that the body had to continually demonstrate “added value” (WHO Interviews 19th October 2007 & 12th November 2007).

While WHO’s first core function - to provide leadership on matters critical to health and to engage in partnerships where joint action is needed – was enshrined in the original WHO Constitution, WHO’s *Eleventh General Global Programme of Work 2006-2015, A Global Health Agenda* (WHO 2006) elevates this function to a new prominence in the new millennium.²⁰³ It states that the new *Programme of Work* differs from the previous ones in that:

“it examines current problems, the challenges they imply, and the ways in which the international community, not just WHO, must respond to them over the next decade. It defines a common health agenda for the world and the actions needed to carry it out” (WHO 2006: 1).

In short, the document underlines that the challenges facing global health require joint action “within and without the conventional health sector”, and as such the organisation’s overarching objective must be to shape “the evolving role of WHO as the directing and coordinating authority in international health work” (WHO 2006: 1).

It is remarkable that out of the numerous challenges *Engaging for Health* addresses, several prove particularly salient to the subject of this thesis: the document records a vast increase in the number of actors engaging in health partnerships over the last decade and the implications this has for accountability, efficiency and coordination;

²⁰³ The principle to coordinate and cooperate with all partners engaged in health is enshrined in the original *WHO Constitution*, which came into force on 7th April 1948. Please note that all UN member states have signed up to WHO’s *Eleventh Global Programme of Work*.

it notes that aid is often not being used to support national health priorities and suggests that developing governments will require more WHO assistance to encourage their various partners to harmonise and align. Finally, it underscores the disproportionate volumes of aid now being targeted at a narrow range of interventions as a result of the surge in global funding initiatives (to the detriment of other programmatic areas). In this manner, while reasserting its role as the authority at the heart of the global health architecture, the *Eleventh Programme for Work* is significant for depicting the changing WHO as a key protagonist within the new architecture of aid. Indeed, it even employs the language of aid effectiveness when it asserts that “WHO will work with others to harmonize the global health architecture, and provide forums for the increasing number and type of entities involved to engage in dialogue on local and global health challenges” (WHO 2006: 31).

So how does this change of global focus translate at the country level in Uganda? Well the first thing to say is that - in the same manner as WHO’s technical guidelines - the crux of its intentionally broad *Programme of Work* has already been systematically disseminated and assimilated through the different tiers of the organisation - from Geneva HQ, to the Regions and finally to the individual WHO Country Office (WCO) – all the while being remoulded according to the scale and the context of the tier in question. The consequence is that a common theme to emerge from all the interviews at the Uganda WCO was the significance of fostering strategic alliances and partnerships at the country level to facilitate the work of the organisation.²⁰⁴ And again to highlight the consistency of the WHO message throughout its tiers, the national government/Ministry of Health was judged in every interview to be WHO’s most important partner within the sector.

The “Global Health Agenda” contained within the *Eleventh Programme of Work* outlines seven priority areas intended to be adopted by all stakeholders (as part of the broader partnerships).²⁰⁵ Crucial to this - a discussion that argues for a direct link

²⁰⁴ A series of interviews were carried out at the WCO between July 2007 and May 2008.

²⁰⁵ The seven priority areas are: 1) investing in health to reduce poverty; 2) building individual and global health security; 3) promoting universal coverage, gender equity and health-related human rights; 4) tackling the determinants of health; 5) strengthening health systems and equitable access; 6)

between the ownership and sustainability of national policies - is that all seven priorities depicts the nation state as the key protagonist in any partnership. To provide some examples, in priority one - investing in health to reduce poverty – one learns that: “The role of government is central” (WHO 2006: 14), while for priority two - building individual and global health security - “Government plays a decisive role” (MoH 2006: 14-15). For a body that derives professional and to some degree moral authority from its extolled neutrality, this pro-state message from the WHO during this, the era of public-private partnerships and ‘good governance’, could be construed as slightly outdated.²⁰⁶ Yet it is depicted in the “Global Agenda” as entirely innocuous and sustained at the country level in Uganda in a similarly understated manner.

While recognising the core function of the UN specialised agency for health to set norms and standards globally, this discussion will focus on the reality of operationalising that mandate. In short, the discussion will confine itself to the mechanics of partnership at the country level because with little core funding at the WCO level (beyond office and staff costs), it is only through the promotion of collaborative working that the overarching WHO mandate can be advanced.²⁰⁷

To turn first to the logistics of the partnership the WCO maintains with the GoU/MoH, the sheer breadth of support offered by WCO attests to the non-monetary value of the relationship to the state. To use the WCO’s support of the national HIV/AIDS programme as a example, one learns that in 2006 the WCO supported the National AIDS Control Programme: to scale up preventative and curative care, to develop and launch a national road map for the acceleration of HIV prevention, to develop and disseminate a new antiretroviral therapy (ART) policy, to develop the *HIV/AIDS Strategic Plan 2007/8-2011/12* (UAC 2007), to develop a national HIV

harnessing knowledge, science and technology; 7) Strengthen governance, leadership and accountability.

²⁰⁶ Chapter Seven will highlight that WHO’s pro-state view is not one shared by the global funding initiatives GFATM and PEPFAR.

²⁰⁷ The biennial budget for the core functions of WCO in Uganda is only about US \$1million, 98% of which is salaries, utilities, rent etc. In addition, WCO may receive some extra-budgetary funds raised at the WHO Geneva or WHO Afro level (although Afro money is rarer and is generally for isolated incidents e.g. epidemics, national immunisation or small proposals in Africa). This amount again is small – around US \$4-5m every two years (WHO Interview 19th July 2007).

drug resistance monitoring plan, to develop patient monitoring tools, to support operational research studies in areas of ART adherence and task shifting, and to build capacity at the district level through the provision of training materials for HIV managers and support for technical supervision visits aimed at strengthening HIV/AIDS service delivery (WCO 2007).²⁰⁸ In addition, and in a manner that benefited both the National Aids Control Programme and the National Tuberculosis (TB) and Malaria Programmes, the WCO also assisted the government with the development of the new Long-Term Institutional Arrangements (aimed at restoring Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) confidence in Uganda) and by assuming the temporary role of third party procurement agent for GFATM commodities while national procurement capacity improves.²⁰⁹

A similar picture of far reaching assistance emerges if we address the support offered by WCO to the National TB programme. In this case WHO technical and financial assistance supported: programme management, planning (including support for the development of a 5-year strategic plan for TB control), monitoring and evaluation, resource mobilisation, capacity building and the strengthening of TB/HIV collaborative efforts in country (including the development of the national policy guidelines). The picture to emerge therefore is of a close and sustained working relationship with Uganda's MoH. While other Health Development Partners may also supply technical assistance to the ministry, the key difference is that theirs is externally commissioned, transitory and, more often than not, employing expatriate staff.

To readdress the "people matter" (Walt *et al.* 1999b: 274) argument previously evoked in the Danida case study, I need to emphasise in this case the comparative advantages of the WCO team over those of donor units. The first point to emphasise is its scale: whereas most donor health teams boast between one and ten staff members, it is incredible to note that in 2006 WCO employed over 70 members of

²⁰⁸ This list is not exhaustive

²⁰⁹ In Chapter Five the point is made that WHO has also played a key role in GFATM proposal development.

staff.²¹⁰ When you consider that a serious charge levelled against harmonisation measures is its time heaviness then one might deduce that a larger team has a better chance of being heard in all fora.²¹¹ While the second point concerns the nationality of the WCO staff, it is only to attest to the longevity of their postings: the majority of the staff are Ugandan and thus it was not an uncommon finding of the fieldwork to encounter staff who had been in their current job for the better part of a decade (at least at the time of fieldwork). To those familiar with the nature of expatriate donor postings, the continuity of the WHO workforce (in Uganda) will resonate. If one agrees that a key facet of partnership activities is personal interaction, one can immediately see the potential of the WCO staff to foster policy consensus with its main partner in Uganda, the MoH. The programmatic examples highlighted above suggest that it does so in several ways. Firstly and most obviously through sustained contact with the Ministry; secondly, by introducing and adapting generic WHO policy guidelines at the national level (in other words by virtue of the organisation's professional authority); and thirdly, by the sheer breath and scale of the organisation's involvement across programmes and fora. I shall deal with each of these points in turn.

The interviews carried out at the WHO Country Office in Uganda dealt exclusively with National Professional Officers (NPOs), a position that aligns members of staff with a WHO programme (e.g. malaria or health systems). This means that in almost all cases the NPO will have a counterpart in a similar department at the MoH, with whom they share a technical focus. In this aspect the WCO team shares something in common with the Danida Support unit except on a much larger scale. Clearly the key difference between the WCO *modus operandi* and that of the Danida Support Unit however, is that while there will be regular contact between the WCO technical staff and their counterparts at the MoH, there remains a physical separation. For the current WHO Representative (WR), this distinction has proved important and it was

²¹⁰ For details on the size and *modus operandi* of Uganda's other Health Development Partner teams see Chapter Four.

²¹¹ An anecdote to support this comment comes from a SIDA representative relatively new to her posting. A one-woman health team, she told me that despite the SIDA programme boasting health and HIV/AIDS components, she had not yet found the time to attend the AIDS Development Partners forum. She simply didn't have the time to attend all of the salient health *and* HIV/AIDS fora (SIDA 22nd May 2008).

interesting that an issue to emerge from the interviews concerned a NPO who had taken up semi-permanent residency at the MoH.²¹² The NPO explained the logic behind his positioning as follows, “[I] took it as if it was better to be next to the partner... So if I needed a file I would just pick it and come back and work. If we needed dialogue we’d simply walk across and talk to the manager and something like that.” A change of WR however, put an end to this arrangement and ordered the NPO in question back to the WCO saying “Why should we sit there like we’re employees of the Ministry of Health?” (Interview 22nd April 2008). It seems in this instance that given its close working relationship with the Ministry, the physical separation of the WCO and MoH staff is symbolic – an assertion of the WHO’s autonomy – and the importance of this is perhaps better understood if I introduce some comments made by external partners during the fieldwork period. The first – from a CSO representative - suggested that the WCO staff were too close to the GoU and not as impartial as they should be (MSF Interview 25th April 2007). The second – from a bilateral donor - alluded to the conflicted positioning of WHO vis à vis a government that is at once a member of the UN and a recipient of its expertise: “I think also they feel they’re in the lap of the government a little...you know it’s complicated, they have like a dual role” (SIDA Interview 22nd May 2008). This latter interviewee suggested there had been a general disappointment amongst the donors that the WR had not been a little bolder at the Health Policy Advisory Committee (the most important multi-stakeholder forum for health in Uganda), although she was sympathetic as to why not. Such comments are too easily reinforced when you consider this NPO statement on the WCO’s working relationship with the MoH: “I think we are brother and sisters... We hardly move without them. Actually we can’t because most of the areas of work we have to agree...they’re the implementers” (WHO Interview 26th November 2007).²¹³

An external perception of the WCO as too close to the Ugandan government and the organisation’s subsequent efforts to maintain a tangible separation highlight a serious

²¹² I refer to the WR that was in place during my fieldwork period. That WR resigned toward the end of my fieldwork period, in Spring 2008.

²¹³ The idea that certain bilateral and multilateral partners enjoy preferential relationships with government ministries is not new, and Lucas *et al.* (1997) affirm that WHO has often held close relations with ministries of health.

complication in the partnership discourse, by suggesting that being on good terms with one partner can actually be to the detriment of other relationships. In the context of the Ugandan health sector where there is a diverse range of external stakeholders, it is enlightening that WHO – possibly the best-placed organisation to influence national policy and in a manner that doesn't challenge national sovereignty – is still under immense pressure to foster partnerships with other stakeholders at the country level if it is not to be discredited. In short, one is reminded that beyond its technical aspects, policy making is also an exercise in diplomacy – a point I shall return to.

The second means through which WHO attempts to build policy consensus at the country level – and probably the best tool in its armoury to defend itself against accusations of government co-option – is of course the organisation's technical expertise.

The WHO of the 21st Century still wields significant influence in developing health sectors, and while Uganda is no longer experiencing the policy vacuum of the 1980s, it is clear that the generic policy guidelines emanating from Geneva HQ continue to make an important contribution to health policy at the national level. Every WHO interviewee described the means through which the agency's global guidelines are made contextually relevant (to align with Uganda's *Health Sector Strategic Plan II*), attesting to the flexibility of the overarching WHO programme. Moreover the *WCO Annual Report* (WCO 2007) underscores how often the main points of the generic guidelines are assimilated into national policy. And yet there is a sticking point, and it's related to an assertion already made in this discussion: that Uganda's health sector is now characterised by a plethora of unfilled policy objectives. As this interviewee said of the WHO's global strategies, "There's flexibility...The objectives are broad and therefore many activities can fit in as changes emerge. The only inflexibility comes in – it must be supported with funding" (WHO Interview 16th November 2007). In short, while WHO may still have the technical authority to wield – the authority to get a policy on the table - there's still the little matter of policy execution, and that in Uganda remains inextricable from the politics of aid.

Before turning our full gaze to the issue of politics in the policy sphere, I would like to underscore the final means through which WCO staff help to build policy consensus at the national level. While I've already touched on the size/scale of the WHO team, I would now like to expand on this point both in terms of the far-reaching remit of the organisation's country programme and the logistical advantage it offers the team when it comes to gaining a say in Uganda's plethora of health-related discussion fora.

Chapter Four served to underline that the individual objectives of Uganda's Health Development Partners tend to differ markedly and focus on a narrow set of programmatic objectives. The exceptions in this grouping are WHO and the religious medical bureaus (the latter provide around 30% of the country's health care services), which both take a horizontal approach to the healthcare system. A cursory look at the WHO Uganda programme attests to the unparalleled remit of the organisation to lobby on behalf of the under funded, unpopular aspects of health care provision. For instance: neglected tropical diseases (NTDs), mental health, substance abuse, injuries, violence, disabilities and general health promotion (WCO 2007). These are the issues that fail to attract notable funding in a country where the budget is prioritised according to the rate of mortality (and is therefore predominantly channelled toward communicable disease). As this NPO said of NTDs "They cause mainly disability and morbidity...They are neglected because mainly they are not associated with high mortality...so even when a donor invests money, he's not going to reap quick results of rapid mortality" (WHO Interview 27th November 2007). The same is true of the non-communicable disease burden - the seriousness of which the MoH has now publicly acknowledged "Uganda is experiencing dual epidemics of communicable and non-communicable diseases" (MoH 2007a: 65). Funding for non-communicable disease continues to be woefully inadequate in Uganda and the WCO reports that: "The current low interest of many development partners is a big challenge" (WCO 2007: 74).

Yet in a discussion about the potential of coordination to foster policy consensus, I would argue that the status of WHO as the champion of the - as yet – overlooked and

under funded aspects of healthcare gives the organisation an unparalleled opportunity to lay the policy groundwork of the future. As evidence, I would cite WHO Uganda's key role in developing national policies on tobacco control and avian flu (in conjunction with other partners) (WCO 2007). To hone in on the avian flu policy, I asked the NPO most closely associated with the policy's development how difficult it was to advocate on behalf of a theoretical threat when established epidemics were recurrent in Uganda. She admitted "it was difficult." Moreover, that the existence of the policy in itself was not sufficient:

"for that little money that was needed for that technical assistance and to get a minimum basic done, the partners were able to provide some funding. But as for the implementation – for what it takes to be well prepared for avian flu – a lot is still to be done using this nice plan because of lack of funding" (WHO Interview 27th November 2007).

The point with both initiatives is that while their impact is unlikely to be felt in the short-term, their existence from the point of view of building policy consensus is significant. Firstly, because they are now in place to inform future interventions in these areas should the need versus funding threshold ever be met. Secondly, because these issues are not typically high up on the average donor agenda, the WCO in conjunction with the MoH has been able to circumvent a lot of the political manoeuvring that accompanies policy development in the health sector. In these instances therefore, WHO's ability to influence policy at the national level has been derived from its far-reaching programme (from its mandate to "be on top of everything"), its technical authority and – in no small measure - to a degree of disinterest from Uganda's other health stakeholders. Thus while Uganda's health system no longer operates in a policy vacuum, isolated policy voids do remain – notable where mortality rates are low and/or donors can't guarantee a quick return in terms of impact rates – and it is in these areas that WHO still excels, working in conjunction with the MoH to develop nationally 'owned' policies.²¹⁴

²¹⁴ A WHO interviewee highlighted the manner in which national ownership of policy is achieved in the WHO-MoH partnership. She explained that while WHO could advocate on issues, it ultimately had to be up to the MoH to make the decisions (Interview 7th November 2007).

This begs the question, what contingency plan does the UN's Specialised Agency for Health have when Uganda's external health stakeholders do display a vested interest in the policy discussion? Here I would draw your attention to an excerpt from WHO's *Eleventh General Global Programme of Work* cited earlier: "WHO will work with others to harmonize the global health architecture, and provide forums for the increasing number and type of entities involved to engage in dialogue on local and global health challenges" (WHO 2006: 31).

In this, the final section of the discussion, I would argue that WHO at all levels has decided to fortify its role as a world technical authority on health with a progressively diplomatic focus. In short, compelled by the new aid environment in health, which champions unprecedented volumes of vertical funding and a multiplicity of partners, WHO has realised it can no longer hand down fixed policy prescriptions and see them unconditionally accepted at the national level. Nor can it rely solely on forging a good relationship with the national government. At the central level in Uganda there now exists a plethora of voices with which the organisation must compete for the government's ear. Rather than pitting itself against those voices, the WHO strategy is to use coordination fora to lobby its partners. In Uganda it does so in two ways: by ensuring the agency is represented at each of the salient forums and, in some instances, by actively leading or facilitating the forum in question. Riddell has commented on this very trend in development, noting its existence but also its essential problem:

"The changing fads and fashions of development have also encouraged agencies, particularly multilateral agencies to put themselves forward as the 'agency of choice' to help implement new development ideas, creating further overlap between and across agencies...Ironically, coordination itself is another area of overlap...there often remains a lack of clarity over precisely which agency has the mandate to coordinate the activities of other aid agencies and what such coordination entails, especially if this is perceived to challenge the authority of the host country itself." Riddell 2007: 87)

The organisational chart included as Appendix 2 to this thesis lays out the formal structure and fora for policy discussion in Uganda's health sector. Within this formal structure, the WCO is represented at each of the fora where nongovernmental

participation is invited, namely the HPAC and the Technical Working Groups (TWGs). To expand on the extent of the organisation's involvement, the WHO Representative (WR) and two members of the WCO Health Systems team regularly attend the HPAC, although additional WCO staff may also be brought along if the need arises; in short WHO is permitted "to co-opt expertise depending on the agenda" (WHO Interview 2nd October 2007). And while WHO is considered to be one of Uganda's Health Development Partners - who are generally represented at the HPAC forum by their elected Chairperson - the WR retains a more prominent position than do the other HDPs – regularly addressing the meeting directly.²¹⁵

To move on now to the TWGs, the thinking behind the organisational structure of the formal policy fora is that the TWGs will discuss the technical aspects of operationalising the *Health Sector Strategic Plan II* before feeding recommendations into the HPAC, which maintains more of a political/diplomatic focus. To provide some examples of the sort of TWGs that exist in Uganda, there is a sector budget working group, one on communicable disease and another on medicines and procurement. Immediately therefore one can detect the advantages that the WCO has over the other HDPs - being able to deliver consistent and far-reaching technical expertise across the full spectrum of TWGs and boasting the size of team necessary to facilitate the accompanying commitment of time.²¹⁶

However, a caveat to the formal organisational structure of Uganda's health sector concerns an on-going complaint heard throughout the fieldwork period that the TWGs were not meeting as often as they should have been (or in some instances at all).²¹⁷ This would clearly pose a serious fault in the WCO strategy if it weren't for the fact that the formal organisational structure is complemented by a multitude of informal coordination networks at the national level which continue to function regardless of the performance of the TWGs. In many instances these networks meet

²¹⁵ Chapter Four explains how the HDPs attempt to reach common positions in their HDP forum, which are voiced by their chairperson at the HPAC. This is to aid the illusion that the HDPs "speak with one voice" when addressing the government. It is also held up as a literal manifestation of the Paris harmonisation objective.

²¹⁶ There are two HDPs representatives within each of the TWGs (Interview 22nd May 2008).

²¹⁷ For example see the closing statement of the HDPs delivered by Chairman Marc Denys at the Technical Review Meeting held in Kampala on 29th May 2008.

more regularly and enjoy a much broader representation of stakeholders than do the TWGs.²¹⁸ The WCO has sought to capitalise on such groupings, again by virtue of its size and far reaching programme - and thus its direct participation in them - but also by increasingly facilitating such forums.²¹⁹ To provide some examples, the WCO has housed the Uganda Stop TB Partnership since 2004 (providing a meeting space and secretariat duties) - a forum which involves 27 partners including representatives from the national TB programme and civil society; in 2006 the WCO became the permanent secretariat of the Health Development Partners at the request of the other partners (WCO 2007); and as the lead organisation of the UN Cluster for Health, Nutrition and HIV/AIDS, the WCO has housed the monthly meetings of the cluster since 2006, helping to coordinate the response of Uganda's humanitarian actors. To elucidate briefly on the health cluster, the "added value" of WHO as the lead agency is two-fold: the WCO is again able to "co-opt expertise" from the broader WHO team dependent on the agenda; moreover, because the organisation has appointed itself as the "provider of last resort," it has made itself accountable for filling any gaps left in the cluster's response (WHO Interview 19th October 2007). This decision to assign accountability to a single partner is extremely unusual for a coordination arrangement.

Thus, while the HPAC is commonly considered the most important forum for debating health policy in Uganda, a closer look at the coordination infrastructure attests to a wealth of discussion fora outside the formal organogram. Furthermore, the significance of such fora is actually elevated in view of the poorly functioning TWGs. WCO, more than any other HDP has attempted to operationalise the rhetoric of partnership at the national level in Uganda by supporting and participating in the broadest possible range of coordination fora. While its professional expertise has traditionally been its main offering in each of the forums, it is of interest that the UN's specialised agency for health is now also facilitating the rudimentary aspects of

²¹⁸ While the HPAC widened its membership to include three civil society representatives in the spring of 2007, the informal fora have always embraced the participation of civil society. Moreover despite the existence of formal fora in the health sector, it attests to the perceived value of the informal networks that Ministry/governmental representation is also quite common.

²¹⁹ For instance the WCO team participates in Uganda's Roll Back Malaria Partnership and the AIDS Development Partners Group.

partnership: the meeting space, the minutes and the refreshments. It is fair to say that this aspect of its work, combined with its close working relationship with the MoH, attests to a 21st Century WHO attempting to cover all bases when it comes to “getting policy right” in Uganda’s health sector.

WHO Case Study Conclusion

In the preceding discussion I have argued that WHO is attempting to build policy consensus in the Ugandan health sector via three means: through a sustained and unrivalled working partnership with the MoH, by virtue of the organisation’s technical authority, and by the sheer breadth and scale of the organisation’s involvement across Uganda’s health programmes and fora. While the pro-state stance and technical expertise are embedded features of the WHO approach, I have posited that in the new millennium, the UN’s specialised agency for health is attempting to add a diplomatic string to its bow. This is a response to the challenges posed by the new aid landscape where official development assistance has been found to subvert the best intentions of policymakers. However, just how well suited the WHO is to assuming this more diplomatic focus is subject to debate.

As suggested, even external partners in-country have challenged the WCO’s public claim to political neutrality, thus exposing the flaw in the partnership rhetoric which fails to underscore that too close a relationship with the government partner – while positive in the sense of fostering policy ownership - has the potential to alienate other stakeholders. Yet the threat of real/perceived government co-option is one easily levelled against any of the UN agencies, and in the case of the WCO I would argue that an increased involvement in discussion fora is one means for it to divert attention away from its weak ability to criticise the national government while simultaneously increasing its appeal and “added value” to other partners.

A second complication involved in the WHO’s diplomatic experiment relates to the ongoing gulf between policymaking and policy execution in Uganda. While not a central focus of this thesis, this does need to be addressed in a discussion that includes two donor case studies. WHO has assigned itself the objective of improving

aid harmonisation and alignment so as to align health budgets with actual need, which poses the question: is it really within its powers to do so? The failure of donors to align their aid allocations with the disease burdens of developing countries is a continuing problem, so perhaps it bodes well that a recent study by Shiffman (2006) has suggested that donor budgets are determined by a combination of three factors: recipient need, provider interest and global policy.²²⁰ Within this mix, WHO would appear to have some of influence over defining recipient need and shaping the global health agenda. Yet, in relation to the socialisation process that accompanies the development of global health policy, it is important to note that WHO is again just one among a growing profusion of voices. That said within Uganda's health sector its ubiquitous presence in a multitude of fora - most notably the Health Development Partners Forum - shows that it is again covering all bases in a bid to use its technical authority to impact on the way that Uganda's donors target their budgets. Indeed, the WCO does use its vantage point to criticise the deployment of the development aid in Uganda. The next case study however, forces us to consider the value of that role when the partner in question appears totally unaffected by the processes of domestic and/or global socialisation.

PEPFAR and the Prerogative to Bypass Policy

Heavily influenced by the aid effectiveness agenda, which advances the properties of harmonisation, ownership, alignment and mutual accountability, the preceding Danida and WHO case studies appear driven by the premise that advancing policy through a democratic coordination model is somehow inherently good and preferable to the "politics of dominance" favoured by development partners during the 1980/90s (Okuonzi & Macrae 1995: 131). The following PEPFAR case study is included to challenge this logic.

²²⁰ The Global Policy Framework suggests that policy stakeholders "exist in an international society, where they are subject to socialization processes. They may not initially know what they want but come to hold particular preferences as a result of socialization by other state and non-state actors into commonly held norms" (Shiffman 2006: 412).

The starting point for examining the PEPFAR programme in Uganda is the reminder that certain donors continue to display a negligible interest in influencing the domestic policies of the countries they give aid to.²²¹ Moreover, that the strategies of these donors - employed in lieu of targeted coordination activities - might actually prove quite effective. This poses something of a challenge to the aid effectiveness agenda and should be addressed.

Other chapters in this thesis deal in depth with the particular *modus operandi* of the US aid model (focusing on the bilateral donor agency USAID).²²² As such – and because there is significant overlap in how the USAID and PEPFAR programmes are managed – I will hone in on just two aspects of the PEPFAR programme: the manner in which its vast funding allotment enables it to delay (or is it to ignore?) adherence to the policy framework for HIV/AIDS developed in Uganda, and the finding that the parallel medicines management system PEPFAR is using to procure HIV/AIDS commodities for Uganda may end up providing the template for the national system.

The *National HIV & AIDS Strategic Plan 2007/08-2011/12: Towards Universal Access (NSP)* is intended to act as “a coordination tool” (UAC 2007: ii) to manage the multi-sectoral and multi-partnered response to HIV/AIDS in Uganda. The cornerstone of the new plan, which has been developed with the input of multiple stakeholders - including WHO and USAID/PEPFAR - is that the prevention component of the tripartite approach (prevention, care and treatment) is to be prioritised. This is a response to the changing nature of Uganda’s HIV/AIDS epidemic.²²³

²²¹ Brainard for example groups the US together with Germany and Japan, on the basis that they are “among the most significant [donors] in dollar terms but are not known for shaping the broader development agenda” (Brainard 2007b: 56).

²²² Chapter Four addresses the *modus operandi* of USAID in some detail, while Chapter Seven explains the manner in which the majority of US money is channelled through nongovernmental “implementing partners,” thus bypassing the state apparatus.

²²³ The *NSP* suggests that Uganda has entered the third phase of its HIV/AIDS epidemic. Whereby phase one was signified by rapidly rising prevalence rates, which peaked around 1992, phase two (1992-2000) saw those rates decline. The third phase of the epidemic (since 2000) has so far been characterised by a stabilisation in prevalence rates, although there’s increasing anecdotal evidence to suggest that there has been an increase in recent years (UAC 2007).

The *NSP* acknowledges the exponential increase in – predominantly external – financial support for the national response in Uganda, yet lists an ongoing challenge to be the following:

“Some external funding is not aligned to national priorities. The allocation of current resources has been inadvertently skewed to develop the country’s capacity to deliver ART to all those in need. This has to some extent diverted attention from other HIV/AIDS services, including prevention and social support” (UAC 2007: 40).

Indeed, this is a serious criticism levelled against the PEPFAR programme in Uganda - a programme that was said to be contributing almost 85% of the national response in 2007.²²⁴ As this WHO commentator said of the programme, “they don’t align with the government plans, they don’t use the monitoring system and they don’t use the coordinating system so...” And while she agreed that the PEPFAR team was happy to work with the Uganda AIDS Commission (to the exclusion of others partners), it was nevertheless perpetuating a very unequal partnership.²²⁵

“PEPFAR has more money than the Ministry of Health budget annually just for HIV. And they don’t want, sorry to say this...but I still believe they do whatever they want. Even the AIDS Control Programme doesn’t have control on that thing because it’s even going over our heads” (WHO Interview 7th November 2007).

To give an idea of the scale of funding the PEPFAR programme is awarding Uganda annually, the proposed amount for FY2008 is \$279 million (Interview 30th April 2008).²²⁶ And to clarify on the notion that control for the programme is “over our heads,” see the USAID/PEPFAR case study in Chapter Four. The ramifications of this arrangement are twofold: PEPFAR funding is not under the same pressure as

²²⁴ Presentation made by Dr David Kihumuro Apuuli – Director General of Uganda AIDS Commission – at the PEPFAR Uganda Dissemination And Stakeholders Consultation held in Kampala on 3rd May 2007.

²²⁵ Uganda AIDS Commission was established as a body corporate for the prevention and control of the HIV/AIDS epidemic in 1992.

²²⁶ The first official evaluation of the PEPFAR programme noted concerns in some focus countries - and particularly among other donors - that PEPFAR was dominating the agenda by virtue of its size. The same evaluation concluded “The scope and size of the U.S. Global AIDS Initiative are closer to the scale of a multilateral than a bilateral effort, and while the United States is not the only donor of funding for HIV/AIDS programs, in some countries its magnitude makes it a dominant source and thus influential in policy and program development” (IOM 2007: 43).

other aid streams to align with national priorities, nor does it have to be channelled through the traditional default aid recipient in Uganda, the Ministry of Finance.

Given the PEPFAR/USAID country team's participation in the consultations that contributed to the development of the new *NSP*, the conflicting involvement of the PEPFAR programme in Uganda needs to be examined. In short, what factors might explain the major discrepancy between the programmatic foci of the PEPFAR and national HIV/AIDS plans?

I would argue that the first clue to this question is derived from the naming of the US aid programme; specifically the letters in the PEPFAR acronym that establish it as an *emergency plan*. To cast back to the beginning of this chapter, even the progressive donor bilateral agency Danida had at one time felt emboldened to challenge the national system following unfettered involvement in the health sector during the 1980s when it had acted in emergency/humanitarian project mode to provide the country with essential health commodities. Furthermore, just as the humanitarian response in Uganda continues to operate largely independently of the national health system, the connotation of implementing an emergency plan continues to suggest that the normal rules of alignment and harmonisation do not apply when it is a humanitarian need that is going unmet.²²⁷ PEPFAR Phase I, which ran from FY2004-2008 (ending at midnight on 30th September 2009), was said to be the “emergency phase” of the US programme, while PEPFAR Phase II (FY2009-2013) is touted to be more about building national capacity and creating long-term sustainability.²²⁸ Thus PEPFAR's non-alignment with the new *NSP* during the fieldwork period (March 2007- June 2008) could feasibly be explained by the persistence of the *emergency phase* of the *emergency plan*, which was supported by a volume of funding that produced its own unstoppable momentum.

²²⁷ It is mainly external, nongovernmental partners – such as those coordinated by the UN Cluster – who meet the emergency/humanitarian health need in Uganda. Even the national budget allotment for such work, while miniscule, is separated from that of the health sector and is housed under the Office of the Prime Minister.

²²⁸ The foci of the two phases were explained at PEPFAR Uganda Dissemination and Stakeholders Consultation held in Kampala on 3rd May 2007.

However, any suggestion that PEPFAR Phase II – which commenced in October 2009 – would be more likely to align with the revised national focus on prevention was not something the HIV/AIDS sub-team leader at USAID could confidently attest to at the time of the fieldwork. As she explained, even the country team wasn't privy to what Phase II would look like (by Spring 2008), and the one advance estimate they had received had suggested that the prevention component would constitute approximately 20% of the revised programme (USAID Interview 30th April 2008) – a figure that would signal no change in the original prevention earmark attached to Phase I. And while a 20% focus wouldn't allude to a total disregard of the *NSP* - which, based on its “high funding scenario” would ideally earmark 28.3% of resources to prevention activities (UAC 2007: 46) - it hardly suggests an ethos of unequivocal donor alignment. An important qualification to make at this point is that a successor to the original PEPFAR 5-year plan was never guaranteed – PEPFAR Phase I was a finite initiative - hence the element of uncertainty about what Phase II might look like even within one of its implementing agencies.²²⁹

To relate this point now to the aid effectiveness agenda and the seeming disregard of the PEPFAR programme to the tenets of alignment and harmonisation, the question remains as to why the future alignment of Phase II with Uganda's *NSP* was never assured, despite the national plan having garnered the input and support of the USAID country team? I would argue that there are three reasons for this. The first underscores that PEPFAR is an international programme and as such its targets and earmarked funding reflect that focus. The original *US Five-year Global HIV/AIDS Strategy* (US Department of State 2004) aimed to prevent 7 million new infections, to treat at least 2 million people, and to provide care and support to 10 million people living with HIV/AIDS in the focus countries during the 5-year programme.²³⁰

²²⁹ The PEPFAR programme was re-authorised in 2008, meaning that we now know what Phase II looks like.

²³⁰ An evaluation of the early years of PEPFAR questions the empirical base of the programme's performance targets, finding “The Leadership Act did not provide a rationale for the derivation of the performance targets for prevention, treatment and care” (IOM 2007: 67). Nevertheless, Oomman *et al.* underline just how important those targets have become: “Progress against these targets is the principle way that Congress assesses PEPFAR's performance; as a result, PEPFAR is highly orientated towards meeting these numerical targets” (Oomman *et al.* 2007: 11). They also note the downside of this approach: “The emphasis on targets leads PEPFAR to prioritise speed and efficiency over factors like sustainability” (Oomman *et al.* 2007: 29).

Moreover, the original Leadership Act that established the Fund in 2003 dictated that PEPFAR money should be allocated as follows: 55% for treatment, 15% for care, 20% for prevention (of which 33.3% be spent on abstinence until marriage programmes) and not less than 10% for orphans and vulnerable children (of which at least 50% shall be provided through NGOs).²³¹ Indeed, the heightened appeal of the treatment component deserves special mention at this point, as it may serve to explain why PEPFAR is unlikely to align with Uganda's prevention focus in the near future. Morrison attributes the prioritisation of the treatment earmark to the USA's fixation on numerical targets and attribution for results:

“Making the case for providing treatment to extend the lives of people living with HIV is inherently more compelling than advocating prevention of HIV infections: the former delivers a tangible service – with observable results – that restores hope for individuals; the latter, when successful, is a nonevent” (Morrison 2007: 82).

Moreover, as he points out, much of the prevention terrain is contested, confused as it is by moral and cultural values (Morrison 2007). On two counts therefore, treatment is established as the more appealing facet of the prevention, treatment, care continuum for donors.²³² This is amply demonstrated in PEPFAR's changing budget allocations over its first three-years: whereby the proportion of funding for treatment increased from 34-45%, while prevention dropped 9%, and care remained constant (IOM 2007: 106). To conclude this point therefore, the Uganda country programme was, and continues to be dictated within the very stringent confines of the

²³¹ The PEPFAR evaluation also questions the evidence base of PEPFAR's original budget allocations, noting that “Relatively little information existed [in 2003] with which to determine precisely how resources should be allocated to achieve the performance targets in the focus countries; thus the budget allocations could not be fully evidence-based. Even in the instances where the available information allowed reasonable estimates, the situation has since changed so rapidly that those estimates are no longer accurate” (IOM 2007: 98).

²³² A bias for treatment transcends the PEPFAR programme; the three largest GHIs operating in HIV/AIDS (PEPFAR, GFATM and the World Bank's MAP) have all been found to be “disproportionately focused on treatment and care at the expense of prevention” (Oomman *et al.* 2007: 62). A similar bias for treatment was unearthed in an analysis of expenditure in Uganda's health sector, which found “Preferential medicines expenditure on large expensive commodities...” (Nabyonga *et al.* 2009: 8). The situation is such that Biehl (2007) has written about the “pharmaceuticalization of public health,” following Brazil's successful efforts to make access to HIV/AIDS treatment universal.

overarching global framework.²³³ This in itself will likely preclude PEPFAR's alignment with Uganda's *NSP* in the near future.

The second issue refers to the first, but also to a point better made in Chapter Four of this thesis, that there are often huge discrepancies between the objectives and sentiments of the in country team versus those of their headquarters (HQ) which, in some instances can render the better intentions of the field staff impotent (Office of the Prime Minister 2008). To elucidate, the HIV/AIDS sub-team leader at USAID affirmed that the country team supported Uganda's push on prevention and suggested they would have to get "creative" to try to support this at the country level despite a potentially conflicting mandate from HQ (USAID Interview 30th April 2008).

The third reason relates to an assumption – indeed the assumption that underpins the aid effectiveness agenda (and which Shiffman (2006) has already called into question) – that donors will prioritise a recipient need framework when attempting to improve the effectiveness of their aid and only then will favour behaviours that promote alignment, ownership and harmonisation. While we continue to work on this assumption, the reasoning behind the stance of the PEPFAR programme remains opaque. It is only when we set it aside and allow for the possibility that the PEPFAR programme is actively prioritising a provider interest framework that its programme objectives begin to make sense. Shiffman makes this point directly when explaining the US administration's burgeoning interest in HIV/AIDS:

“A provider interest framework presumes that the interests of constituencies in industrialized states are paramount. Donors may prioritise a disease because political elites perceive a disease to be a national threat. For instance, in 2000 the Clinton administration labelled the global spread of HIV/AIDS a national security threat...In consequence, for the first time the United States

²³³ The targets for Phase II are as follows: treat 3 million, prevent 12 million new infections and provide care for 12 million. The funding conditions for Phase II aren't as strict as in Phase I but remain quite specific. Guidelines stipulate that over half of the funds must be spent on treatment and that at least half of all money directed towards preventing sexual HIV transmission should be for: “activities promoting abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction.” <http://www.pepfar.gov/documents/organization/108294.pdf> [Accessed 22/06/09].

Security Council became involved in the fight against an infectious disease” (Shiffman 2006: 412; also see Morrison 2007 and IOM 2007).²³⁴

Indeed, the point Shiffman alludes to here about the inclusion of the US Security Council is borne out by the multi-agency approach adopted by the PEPFAR programme, which sees a host of US agencies, beyond the traditional bilateral aid agency USAID, appointed as the plan’s “implementing agencies.”²³⁵

Furthermore, this provider interest theory goes some way to explaining why domestic policy is not awarded the same degree of reverence by the PEPFAR programme as it is by say, the Danida or WHO programmes. In short, the US administration having assumed ownership of the threat posed by the HIV/AIDS pandemic has similarly chosen to retain ownership of the policy framework that accompanies it. From this standpoint the importance of making Phase I of the PEPFAR programme an ‘emergency phase’ begins to take on new meaning: the evocation of a humanitarian intervention imbued the programme with a moral authority to bypass the red tape and institutional inadequacies of the aid recipient country to reap quick results, while failing to make it entirely explicit that the threat identified was one to Homeland security.²³⁶

²³⁴ Morrison likens the US’s conceptualisation of HIV/AIDS to that of terror, explaining its public appeal: “In post-September 11 America, HIV/AIDS inherently resonated with the public’s new, raw consciousness of terror. Here was a disease with special, pernicious properties: it lay unseen, spreading quietly for years” (Morrison 2007: 72). An evaluation of PEPFAR also points to the loftier goals of the programme, noting that “Global security is profoundly influenced by our increasing health interdependence... The PEPFAR initiative should be seen not only as an important investment in the lives of many individuals and their families, but also as an investment in global security” (IOM 2007: xi).

²³⁵ The following US government departments are described as PEPFAR implementing agencies: the Department of State, USAID, the Department of Defence, the Department of Commerce, the Department of Labour, the Department of Health and Human Services, and the Peace Corps. <http://www.pepfar.gov/agencies/index.htm> [Accessed 17/06/09].

²³⁶ Oomman *et al.* (2007) record praise for the PEPFAR programme, in relation to its speedy disbursement and user-friendly funding request system. Yet they are also explicit that “PEPFAR money is channelled primarily outside the government system. Recipient governments are not involved in oversight, although they do receive information about planned activities from PEPFAR staff” (Oomman *et al.* 2007: 29). Nabyonga *et al.* acknowledge the implications of this mode of working for Uganda: “Given the slow bureaucracy in the public systems, donors may prefer to bypass the national systems and spend the money among the private sector for quick results. The implication is increased expenditure on non-HSSP objectives, poor alignment on sectoral expenditure, and overall poor effectiveness of donor aid” (Nabyonga *et al.* 2009: 9).

During its emergency phase the PEPFAR programme enjoyed five years of relative freedom to bypass the policy mechanisms and national systems that impinge on the daily lives of Uganda's other Health and AIDS Development Partners. During this time, PEPFAR became an embedded component of the HIV/AIDS response in Uganda (compare the relative financial security of the ever increasing PEPFAR funding to the unpredictable and fragmented GFATM rounds).²³⁷ Consequently, one might posit why now, in its second phase, the programme should chose to opt into a more meaningful partnership at the country level when not mandated to do so. Moreover, if the main argument used to persuade the US administration to adopt the tenets of alignment, ownership and harmonisation is centred on the logic of the aid effectiveness agenda, then the case presented could appear fairly unconvincing. A surprise finding of a report tied in with the development of the *3-Year Rolling Procurement Plan for Essential Medicines and Health Supplies* was that the medical supply chain management model employed by the PEPFAR programme – which has been highly criticised in Uganda for bypassing the national system – has proved incredibly successful (MoH 2007d).

The topic of medical procurement and supply management provides a common strand with which to juxtapose the programmatic approaches of the three Health Development Partners addressed in this chapter, because while Danida and WHO have opted to play the long game in Uganda's health sector, the PEPFAR has performed more in the role of an humanitarian aid programme. Of course the framing of the diverging approaches is central to their justification: while Danida and WHO concern themselves with the Paris tenet of 'ownership' and the long-term sustainability of policy in view of Uganda's maturing sector-wide approach in health, the PEPFAR programme is dealing with a global emergency. The approaches pit capacity and consensus building against unfettered intervention.

²³⁷ Indeed the unusual and strained relationship between the GFATM and PEPFAR deserves special mention, as the US has played an integral role in undermining the influence of the multilateral aid instrument in recent years. Morrison describes the competition that now exists between the two instruments as "zero sum" (Morrison 2007: 83), noting that the US has fallen short of its original commitments to the GFATM, challenging the Fund's ability to meet its existing commitment and/or emerging demands. Brainard (2007a) has attributed the US's declining interest in the GFATM with its general intolerance of multilateralism.

The emergency framing of the PEPFAR programme is applied to the issue of supply chain management in the *US Global Five-Year Global HIV/AIDS Strategy*. In a section entitled “rapidly scale up supply chain management to support HIV/AIDS treatment, prevention and care,” the intention to bypass national structures is made explicit:

“In the short-term, the approach will require a combination of outsourcing some logistics functions to the private sector, rapidly building a vertical distribution and information management system with external technical assistance, and improving the storage conditions, distribution networks, and human capacity skills...” (US Department of State 2004: 70).

How this translates on the ground is that the PEPFAR programme contracts John Snow Inc/DELIVER, an American company which uses the Medical Access model, to procure antiretrovirals (ARVs) for Uganda.²³⁸ Once in the country, PEPFAR then contracts the National Medical Stores (NMS) to store the ARVs, before using the Medical Access model again for distribution. PEPFAR also funds some technical assistance in country with regards to the procurement system, which shall be elucidated on shortly. The main point to emphasise here however, is that the way donors are supposed to procure, store and distribute in Uganda is through NMS. The PEPFAR practice of simply using the national procurement agent for 3rd party storage has been hugely frowned upon in Uganda. Yet even the *NSP* acknowledges that “weakness in the forecasting, procurement, and distribution/supply chain” (UAC 2007: 36) is weakening the HIV/AIDS response in Uganda and resulting in frequent stock-outs of essential commodities.

The weakness in the national procurement system is the reason each of the Health Development Partners addressed in this chapter have dedicated resources to it. The national *3-Year Rolling Plan* developed with technical input from Danida and WHO is a direct response to the current problems, and it is a part of the whole process of advocating on behalf of, and rolling out that plan that the WHO contributed to *An Evaluation of the First Rolling 3-Year Plan: Year 1 Implementation of the Plan*

²³⁸ <http://www.jsi.com>
<http://deliver.jsi.com> [Accessed 23/06/09].

(MoH 2007d). The *Evaluation* unearthed three major findings: that Uganda continued to experience an unacceptable level of essential supply stock outs, that the GFATM – which also uses a parallel procurement agent – showed a budget performance of just 61% (i.e. of pledged versus received procurements) and that the Medical Access model employed by PEPFAR had performed beyond everyone's expectations. As this WHO commentator said of the PEPFAR result:

“Contrary to what most of us has been thinking in the past about the inefficiencies of PEPFAR, the evaluation finds that actually PEPFAR has done so well. So well. Very efficiently. In fact there's a recommendation that we better rethink the issue of PEPFAR. Very strange” (WHO Interview ii 8th November 2007).

The comment above again underscores the unchallenged assumption underpinning the aid effectiveness debate (that parallel working has to be bad). It is revealing to note how deeply the assumption is now embedded in the day-to-day working of Uganda's Health Development Partners.

To expand on the findings of the evaluation in regards to the Medical Access model, a central attribute of the US model was identified as its ability to track ARVs all the way from the supplier to the end beneficiaries. This denotes a degree of micro management not yet available within the national system, yet one very much in keeping with the demands of the world's most risk-averse bilateral donor. The ramifications of the findings are such that the evaluation goes on to make this surprising recommendation:

“The Medical Access model could be scaled up to the handle GF-ARV [Global Fund ARV] procurement in the short term (FY 08-09), and replicated – possibly as a prime vendor model with storage and distribution facilities nested within NMS – for public sector provision of ARVs in the medium to longer term.” (FY 09-10)” (MoH 2007d: 7).

The recommendation to replicate the procurement model utilised by the PEPFAR programme in Uganda signals a major change in stance toward the US programme within the country. Whereas its mode of parallel working had previously provoked calls for an immediate change of working, the new consensus is “you do not want to

disrupt their system and bring it into the mainstream which is inefficient. Rather, why don't you study what they're doing and see if you can get some lessons?" (WHO Interview ii 8th November 2007). The finding and the response both point to the lack of empirical grounding of the aid effectiveness agenda, and demonstrate how quickly embedded assumptions can be upturned when the evidence is finally presented.

So far this part of the PEPFAR case study has juxtaposed the PEPFAR and Danida/WHO approaches in the area of medical supply management. I need now to add another layer of complexity, because the fact is that the USAID/PEPFAR programme funds technical support to the National Medical Stores. Furthermore, it is a vocal supporter of the *3-Year Rolling Plan* at the country level and is now proposing to station an ARV logistics person in the medicines management division of the MoH to help with the operationalisation of the plan (in the same division as the Danida Medicines Management Advisor is situated). In short, this aspect of the US aid programme is hugely contradictory: for while it supports the national system with technical assistance and has agreed to feed programme data into the *3-Year Rolling Plan*, it remains adamantly opposed to using the national system except as a storage facility. Finally, and to confuse matters even more, the findings of the *Rolling Plan Evaluation* mean its conflicted stance has now garnered some reluctant support at the country level.

While it is not the objective of this chapter to unearth the undisclosed objectives of the PEPFAR programme in Uganda, a source of contention related to its funding of technical assistance to the NMS is worth exploring. In 2007 the PEPFAR programme asked Supply Chain Management Systems (SCMS) to carry out an evaluation of NMS.²³⁹ The resulting report provoked a strong response from those of Uganda's Health Development Partners with a history of providing long-term support to the

²³⁹ Supply Chain Management Systems is a PEPFAR-funded project, implemented by The Partnership for Supply Chain Management. The latter is a consortium of 17 companies (with a specialisation in providing procurement and logistical support), established in late 2005 by PEPFAR, and managed under a contract with USAID. "The stated goal of the partnership is to support the provision of an uninterrupted supply of HIV/AIDS commodities flowing through an accountable system" (IOM 2007: 162).

organisation, notably WHO and Danida. Yet the complaints voiced weren't concerned with the report's controversial content – for instance describing the new Danida-funded warehouse as: “fit for the storage of expired drugs” and suggesting Danida should pay for a new software system (Danida Interview 9th May 2008) – but with its lack of transparency and the bullish manner in which SCMS appeared to be attempting to foist its recommendations on the country. A central issue (at the time of fieldwork) was that Uganda's health stakeholders hadn't been able to access the full report – despite its main findings being readily disseminated – with SCMS apparently unwilling to release it. As this WHO commentator explained, the salient MoH technical working group had repeatedly asked that the report be officially submitted so that it would have the chance to respond to it. By November 2007, he said he was now growing concerned because “They have not done that. They prefer to go and talk to some big person there, some big person there. We hope that big person will veto or prevail...but it could backfire.” This same interviewee perceived that SCMS had “an agenda” and that this was “to substitute NMS” (WHO Interview ii 8th November 2007).

Given what is known about the private funding agreement the PEPFAR programme has signed up in Uganda, the suggestion that one of its project partners might be attempting to veto the official policy discussion mechanisms is hardly far fetched.²⁴⁰ Moreover, as the WHO interviewee underlined, the PEPFAR programme has form of contracting external partners who over time appear to become permanent fixtures of the national response. Here he cites the USAID-funded DELIVER/JSI, the organisation responsible for introducing the Medical Access model, and which has been supplying the country with ARVs so successfully for the past five years (WHO Interview ii 8th November 2008). Indeed, an evaluation of the early years of PEPFAR also make explicit mention of the Partnership for Supply Chain Management Systems (the PEPFAR-established consortium which implements SCMS), attesting that the concerns raised in Uganda are not isolated. The evaluation criticises the Partnership for “lacking adequate transparency in sharing plans for an exit strategy” (IOM 2007: 164), and suggests it may actually be undermining national supply

²⁴⁰ The private funding agreement that allows PEPFAR to channel off-plan and off-budget funds into Uganda's health sector is addressed in Chapter Four.

capacity by operating a parallel system.²⁴¹ Certainly, a look on the SCMS website in 2010 fails to contradict such concerns, as it becomes clear that the PEPFAR-supported project is now well established in Uganda and rapidly diversifying its interests.²⁴²

PEPFAR Case Study Conclusion

An examination of the PEPFAR programme in Uganda provides an interesting juxtaposition to the Danida and WHO case studies. As a prism through which to view the substantive value of the aid effectiveness agenda it plays a devil's advocate role, showing that the behaviours advocated in the agenda are subject to challenge. Indeed, the picture to emerge of the PEPFAR programme when judged by the standards of the agenda is strangely conflicting. Thus is the programme bypassing national policy or trying to reconcile a global agenda to a local one? Is it undermining the short-term capacity of the national procurement system or providing a possible template for its long-term development? Is it building the capacity of National Medical Stores or planning its demise?

I would argue that when it comes to PEPFAR, the issues continue to be confused by three factors: the 'emergency' tag attached to the programme at the country level which originally gave it free reign to bypass the national system, by the scale and channels of its aid, and to a lesser extent, by the external perception of the US HIV/AIDS programme as being in some way suspicious – a perception which the programme at once condemns yet conspires to perpetuate through its lack of transparency.²⁴³ What is clear is that the assumptions that underpin the aid effectiveness agenda – while not empirically based – have come to provide an acceptable means for partners to denigrate the US programme. However, it is a non

²⁴¹ WHO echoes this concern: "A particular concern is that when improvements result from the creation of parallel systems by GHIs, they may compromise opportunities to help build and maintain a country's own procurement and management supply system" (WHO 2009: 4). A final concern shared by the WHO and the PEPFAR evaluation relates to the sustainability of such arrangements (IOM 2007; WHO 2009).

²⁴² Having initially been brought in to carry out a discrete evaluation in 2007, SCMS has since moved into quantification and forecasting, procurement, logistics capacity management and warehouse management in Uganda. <http://scms.pfscm.org/scms/where/ug> [Accessed 10/05/10].

²⁴³ *PEPFAR Implementation: Progress and Promise* attests to the lack of transparency in the aid programme (IOM 2007).

sequitur to suggest that because the PEPFAR programme is not ‘aligned’, ‘harmonised’, or ‘owned’ it is not successful.

USAID/PEPFAR staff regularly participate in the country’s health coordination fora, attending the Health Development Partners Group, the AIDS Development Partners Group, the Health Policy Advisory Committee and the technical working group on communicable disease. In addition, they organise their own fora, like the PEPFAR Uganda Dissemination and Stakeholders Consultation (which I myself attended in May 2007). Yet just how meaningful their participation can be in such arenas in light of the Congressional earmarking and numerical targets governing the PEPFAR programme is questionable. Could it be therefore, that the USAID/PEPFAR programme is genuinely interested in a bit of self-legitimisation abroad, and/or that the programme could eventually win round its critics with more concerted efforts at diplomacy and consensus building in country? I for one would like to think so. Certainly, regardless of its early bullish reputation in Uganda, the aid programme has its partners in a bind: the scale of PEPFAR funding to the country is now such that Uganda’s HIV/AIDS and health stakeholders have no choice but to engage with it. To put it into the words of one Health Development Partner: “They [PEPFAR] are the ones who have the money so we have to find a way of bringing them into the picture but it’s not easy” (WHO Interview 7th November 2007).

Conclusion

In this discussion I have juxtaposed three very different organisations to demonstrate some of the ways in which Uganda’s Health Development Partners are attempting to build policy consensus to further their organisational objectives in country. My intention was never to pit one organisation against the other, just to illustrate that even development partners like Danida and WHO – who appear to demonstrate a genuine commitment to the Paris principle of ownership - are engaged in acts of self-legitimisation when they attempt to win policy approval through coordination activities at the country level. This is not a cynical position, but rather one that

commends the efforts of those development partners who work to reconcile their organisational objectives to those of their host country. If, at the end of the day the rewards of such efforts are a) the continuance of aid flows (through Danida), or b) the vindication of a *raison d'être* (for WHO) than so be it. It is not cynical to be realistic about the competitiveness that drives the modern aid industry (itself once a vocal proponent of market-centric, neoliberal values). Indeed, given the sterling reputation of the Danida health programme in Uganda, it may come as something of a surprise to learn that it too was waiting to hear its fate in the division of labour exercise taking place in Uganda's health sector at the time of fieldwork, with the indications being that it would leave (Interview 7th May 2008). In short, Danida (like Nordic counterpart SIDA) was found to be taking its Paris commitments very seriously.

However, the inclusion of the USAID/PEPFAR case study in this chapter reminds us that for most signatories, the Paris Declaration is continued to be viewed as a pick and mix checklist, whereby the more inconvenient commitments can be overlooked. Thus while the evidence cited in the USAID/PEPFAR case study would suggest that USAID/PEPFAR is not subject to the same preoccupation with policy as Uganda's other HDPs, this should not be equated with a general disinterest in legitimisation. The difference between Danida and WHO, and PEPFAR is that the PEPFAR programme is legitimised not by validation within focus countries but by meeting the performance targets established for it in Washington. By owning the threat posed by the HIV/AIDS pandemic, and framing PEPFAR as a humanitarian initiative, the US PEPFAR programme has redesigned the incentive structure for aid. Subsequently, it has (thus far) sidestepped the need to seriously impact on HIV/AIDS policy in Uganda. However, PEPFAR Phase II might yet force the US programme out of isolation, as it transitions from emergency mode to a sustainable, systems strengthening approach. While in emergency mode there was at least some suggestion that PEPFAR might eventually leave Uganda. The current indications of Phase II are that it'll be there for some time. Perhaps facing a long game, even the PEPFAR programme will develop a penchant for policy.

CHAPTER SEVEN:

COORDINATION TO DILUTE THE CONTROL OF THE STATE

Introduction

The clarion call of the neoliberal agenda was the diversification of actors and funding sources within health provision to capitalise on the market and compensate for the inefficiencies of the state. With old-school neoliberalism out of favour, development's 'good governance agenda' has served to sustain the message, although in this instance emphasising the developing state's deficiencies in absorptive and institutional capacity, and proselytising on behalf of the democratisation of health (GFATM 2008b).²⁴⁴ Wood (1997) has underscored the distinction, noting that under the 'good governance' agenda the state's role is at once reinstated and curtailed: today the state is there to define, guarantee and regulate health entitlements, not to single-handedly deliver services. Such thinking has paved the way for the proliferation of private and non-governmental organisations in development and laid the foundations for a binary framing in development, which serves to depict the developing state in terms of its weaknesses and civil society in terms of its strengths (Crewe and Harrison (1998) have noted the development industry's tendency toward oversimplification and paired opposites).

Korten (1990) was first to note the growing tendency for civil society organisations (CSOs) to be employed as 'public service contractors' in developing countries, with Robinson (1997) establishing that support for this trend emanated predominantly from donors. In this chapter, I examine this trend in Uganda, positing that aid donors are capitalising on the coordination drive in the health sector to attempt to dilute state control. They are doing so through the promotion and facilitation of increased civil

²⁴⁴ The promotion of CSO activity in developing health systems is a natural corollary of the good governance agenda promoted by the World Bank, which since 1998, has been advocating for an increased role for non-governmental players in developing public sectors (World Bank 1998).

society participation in each aspect of the sector's delivery and deliberation mechanisms. Riddell (2007) laid the foundations for such an investigation, noting that:

“A growing number of official donors view NGOs [non-governmental organisations] not merely as different from, and as working in parallel to, recipient governments, but as a means of *bypassing* governments which they judge to be either not sufficiently committed to or unable to deliver the poverty-reducing impact required” (Riddell 2007: 160).

While civil society organisations (CSOs) in Uganda – and in particular Faith-Based Organisations – enjoy a long-standing tradition as service providers within the country, the key difference defining the current aid climate is for their influence to be formalised and extended from the parish/district level to the centre, thanks in a large part to support issuing from the Health Development Partners and the Global Health Initiatives - specifically the Global Fund to Fight AIDS, Tuberculosis and Malaria and the President's Emergency Plan For AIDS Relief. The result is a sharp increase in the number and diversity of stakeholder voices represented at Uganda's foremost health discussion forum, the Health Policy Advisory Committee. In short therefore, a very literal manifestation of state dilution is being *prescribed* by health donors in Uganda.

In forwarding the proposition that coordination measures in Uganda's health sector attempt to check state dominance, I shall pinpoint three developments as supporting evidence: the Long-Term Institutional Arrangements (LTIAAs) - devised initially for the Global Fund to Fight AIDS, TB and Malaria but now proclaimed as the blueprint for all aid-centric relations; the new basket funding mechanism for CSOs: Uganda's 'Civil Society Fund' - itself a by product of the LTIAAs; and the supplementary coordination networks being established – at least in part - to provide a united voice for Uganda's third sector at centre-led discussion forums.²⁴⁵

²⁴⁵ Rather than being contained in one document, the LTIAAs have been refined via a series of documents, which express the iterative exchange the country was engaged in with the Global Fund Secretariat during 2006 and 2007. I draw on five of those documents in my thesis. References for these are to be found in an annexed section at the end of the main bibliography. An explanation of what is meant by basket funding can be found in box 1 p23-24.

Before addressing these developments in detail however, it is important to briefly acknowledge the concessions to centralised dominance the Ugandan state has already made in relation to its health sector - via its decentralisation model and sector-wide approach (SWAp) – and impress the unlikelihood that it will prove a passive observer when faced with subtle attempts to dilute its influence further.²⁴⁶ Rather, Uganda’s experiences of both decentralisation and the SWAp should demonstrate that the nation state has, and will continue to actively negotiate proposed concessions to its authority. In this way, the current efforts of Uganda’s Development Partners threaten to evoke Ferguson’s anti-politics machine, with development *appearing* to depoliticise everything it touches, all the while performing “its own pre-eminently political operation of expanding bureaucratic state power” (Ferguson 1990: xv).

Decentralisation and the Sector-Wide Approach

As Chapter Two has already suggested, Uganda’s 1990’s health reforms garnered widespread international praise and attention for the NRM government. Yet, as numerous case studies latterly stimulated by the reforms now attest, they have to some extent failed to issue the radical curtailment of central power they once inferred. Nonetheless, as I shall discuss, they can still be argued to have laid the foundations for the recent challenges to state power that form the basis of this chapter.

According to the Rondinelli (1981) typology, Uganda has employed the “devolution” model of decentralisation where the main emphasis is on strengthening local government to enable it to assume responsibility for service provision at the district and sub-district levels. A key feature of the Ugandan model has been to award the country’s districts with block grants to spend according to district-owned work plans. Yet however radical this move may have originally been viewed (Bossert and Beauvais 2002), the “discretionary” component – i.e. the proportion of the grant that the district is wholly free to allocate - has been found to be seriously constrained in

²⁴⁶ An explanation of what is meant by a sector-wide approach can also be found in box 1 p23-24.

Uganda (Hutchinson 1998), undermining the potential check to state power that decentralisation was anticipated to facilitate. Thus, by financial year 2006/07, local governments were found to receive “up to 10% flexibility in the use of the sector recurrent conditional grant non-wage to finance either un-funded or under-funded activities within a sector or in another sector” (MoH 2007a: 92).

Moreover, just as Uganda’s centre has retained its financial dominance over the districts despite the decentralisation model, the districts have also been found to be sidelined by the various coordination forums discussing health policy in Uganda’s capital: “While district representatives participate in various SWAp-related structures (e.g. JRM and TWGs), these structures remain largely under the control of the centre, and the extent to which the districts play an active role in these structures is questionable” (Oliveira-Crux *et al.* 2006: 32). The degree to which this marginalisation has occurred as a result of geographical barriers as opposed to firm intent deserves careful consideration; for instance Jeppsson would suggest that gathering district officials outside their respective districts has “symbolic value” (Jeppsson 2002: 2053) and denotes that processes are run according to conditions determined by the centre. Irrespective of whether or not you take this view however, the ramifications of exclusion remain the same: despite decentralisation in Uganda, the local government input at the central level is curtailed and districts are compelled to align annual work-plans to national policies, the development of which they have enjoyed very limited input into.²⁴⁷

The next feature of the Ugandan decentralisation model however, can be argued to have laid the foundations for the enlarged role the Long-Term Institutional Arrangements have now earmarked for civil society in Uganda’s health sector: the permission for districts to contract services out to CSOs.

²⁴⁷ Having examined the decentralisation process in the health and forestry sectors in Nepal, Harper and Tarnowski had cause to wonder if decentralisation wasn’t actually consolidating the state’s dominance, noting “Paradoxically, or so it seems to us, despite enunciatory claims to centralization, these programmes are producing an entire apparatus through which the state is able to govern its people, its health and management of resources, in an increasingly centralized manner” (Harper and Tarnowski: 34).

“In Uganda, district governments were permitted to contract out services to non-governmental organizations and mission health providers. NGOs managed nearly a fifth of all health facilities in Uganda and their already significant influence was expected to grow as decentralization permitted service contracting” (Bossert and Beauvais 2002: 23).

I shall argue that it is currently the augmented role envisioned for CSOs - rather than the districts - that represents the covert threat to state control underpinning the coordination rhetoric that characterises Uganda’s health sector. Firstly however, it is necessary to situate the recent ascendancy of CSO influence in another health system reform of the period: the Sector-Wide Approach (SWAp).

Uganda’s SWAp represents another reform that has fallen short of the expectations placed upon it to mitigate state control over the sector. Again, this has partially derived from assumptions incurred by sector decentralisation, which affirm that the centre’s role is changed from one of service provision to one of stewardship:

“What makes SWAp attractive is that they are perceived as being able to strengthen governments’ ability to oversee the entire health sector, develop policy and plans, and allocate and manage resources. They envisage a different and expanded role for MoHs, for example, where policy-makers will look beyond the public sector, to explore the potential role of other stakeholders, whether service deliverers in the private sector or financiers” (Walt *et al.* 1999b: 280).

Key to this statement – with regards to this discussion - is the notion that the state can explore the potential of non-governmental stakeholders to assist with service provision in Uganda; indeed other commentators have built on this idea, claiming that “SWAp, at least in theory, encourage the input of civil society in both the design and monitoring of government sector policies and practices” (Elseby *et al.* 2005: 153). Naturally, this argument is made all the more vehemently in a developing country context where the budget envelope for health is notoriously constrained.

Yet, while Uganda’s SWAp certainly set the stage to increase the number of CSOs involved in health service implementation, it has so far failed to demonstrate its

potential to increase non-governmental input into sector decision making or policy setting. To elucidate, one study found that while local governments had invited CSOs to attend district level committees, this did not in itself guarantee “a two-way flow of information.” Instead it seemed the intention of the district authorities was simply to advise and coordinate the CSOs; and that they were “not as yet ready to accept the role of civil society organisations in advocating the health needs of women and men” (Elsey *et al.* 2005: 154). Similarly, at the central level, Jeppsson’s 2002 study failed to find any evidence of increased sway being enjoyed by Uganda’s health service implementers – whether district or CSO-based - as an outcome of the SWAP. Instead districts were experiencing the same treatment they had been doling out to CSOs - facing a prescriptive MoH as opposed to a facilitative one.

An unexpected consequence of the Ugandan SWAp therefore was an *augmentation* of state influence at the centre. Interestingly, Jeppsson attributes the reaffirmation of state power during SWAp development as a consequence of the processes involved:

“During the SWAp process in Uganda, the role of the MoH has emerged clearer and stronger...most important is the power emerging from the negotiation process proper, which is the core of the SWAp process. The main questions are who directs the process, who participates in the process and who decides the boundaries of the sector and what it should contain. The process is seen as a stage where power relations interact” (Jeppsson 2002: 2059).

This point is a crucial one considering the central role processes now play in coordination fora in Uganda. Earlier chapters have offered up numerous examples of how the rules of engagement between the Government of Uganda and its Health Development Partners have been negotiated and formalised over the years in line with aid effectiveness rhetoric concerning ‘coordination’, ‘harmonisation’, ‘ownership’ and ‘alignment’; and, given the amount of energy both sides have evidently expended into deciding upon them, it should come as no surprise to find that issues of power and control are at their crux. What is interesting to this discussion however, is the success with which the Ugandan state has so far defended its dominance over the health sector in spite of its professed adherence to radical

sector reforms. That this has been achieved through deceptively bureaucratic processes is instructive.

So far I have attempted to demonstrate that while the reforms instigated by Uganda's central government have certainly facilitated a diversification and increase in the number of stakeholders engaged in health service provision, it was a non sequitur that the value the state attached to the districts and CSOs as health implementers would extend to see it consulting them on matters of policy or financing. What follows in this chapter therefore, is a discussion of the recent developments in the health sector that appear to hold renewed potential for CSOs to challenge the centre's dominance. Promoted under the guise of aid effectiveness and its drive towards increased 'coordination', it is critical that two of the three developments discussed – the Long Term Institutional Arrangements and civil society's emerging coordination forums – draw on the limited concessions already made by the government via the decentralisation and SWAp reforms and are primarily concerned with getting civil society involved in the "negotiation process proper" (Jeppsson 2002: 2059); while the remainder – the 'Civil Society Fund' - aims to bypass the processes of government altogether using a re-working of the donor project modality: basket funding. Yet, whether central to, or actively bypassing the centrally-owned processes, the three developments hold one thing in common: each is being heavily promoted by Uganda's donors to the health sector - the Health Development Partners and the Global Health Initiatives. Notably, the Ministry of Health is also openly embracing each of the three developments whole-heartedly. Although, as established, the Ugandan nation state has repeatedly demonstrated its ability to subvert the best attempts of its development partners to dilute its control even when ostensibly toeing the line.

The Long-Term Institutional Arrangements

The Long-Term Institutional Arrangements (LTIA) devised for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) can be seen to have capitalised on the concessions made by the Ugandan Government to civil society in the original decentralisation and SWAp arrangements by finally offering it meaningful participation in Uganda's "negotiation process proper" (Jeppsson 2002: 2059). Two key features of its recent promotion include representation at the Health Policy Advisory Committee (HPAC) and the future appointment of a second Principal Recipient from civil society to manage Global Fund grants for the non-public sector.²⁴⁸ I shall elucidate on the precise nature of the dispensations the LTIA has made for Uganda's CSOs shortly. Firstly however, it is necessary to situate them within the broader ethos of the GFATM.

The GFATM and Civil Society

A cursory look at GFATM discourse highlights the diverse range of values the aid instrument attaches to non-governmental organisations in recipient countries. They are at once depicted as central to the GFATM's creation, as advocates for policy change and future funding, and as articulating the voice of people living with the three diseases. Furthermore, for CSOs engaged in service provision, it is suggested that they are key to scaling up health provision and grant absorption in recipient countries (GFATM 2007a). Finally, and in line with current 'good governance' rhetoric, they are attached additional values as catalysts "for democratic processes as vulnerable and marginalized groups acquire more and more a key voice in national policy" (GFATM 2007a: 29); and as watchdogs, guarding against the worst failings of the nation state: "The sense of ownership that civil society has with regards to the Global Fund is a critical motivating factor for them to act as watchdog, holding countries as well as the Global Fund accountable for these finite resources" (GFATM 2007a: 14). Indeed, this latter value deserves further attention in the Ugandan case, because it was in fact a Ugandan CSO that turned whistleblower in the GFATM

²⁴⁸ The role of Principal Recipient for GFATM monies is explained in box 8, p41.

mismanagement scandal (Cohen 2008).²⁴⁹ Remarkable no doubt, but rather than being the exception that proves the rule, this one-off incidence of civil society holding government to account in Uganda needs to be put into perspective. The *CIVICUS Global Survey of the State of Civil Society* (Heinrich 2007) – which evaluates the quality and role of civil society in 44 case country studies – makes clear that the capacity of global civil society to perform in a watchdog role or even input into national budgetary decisions remains grossly underdeveloped (Riddell 2007 also points to the inadequate evidence base to support the argument that CSOs can deepen the transparency and/or accountability of institutions in aid-recipient countries). As I have readily observed in development therefore, it's the single case example and not the broader sample that has set the international agenda for the aid donors. Moreover, as I have come to expect, the purposive case study getting the most mileage is Uganda.

In view of the multitude of values the GFATM has attached to civil society it should come as no surprise to learn that the GFATM is vigorously pushing the need to include CSO representation in the processes of government at the country level. That several of the values it has identified are ideological rather than empirical is at no point depicted as an impediment to CSO potential.

The Country Coordinating Mechanism (CCM) is the vehicle the GFATM has fixed upon to facilitate CSO participation in grant receiving countries - this is the coordination mechanism through which GFATM country proposals are developed and grant implementation is monitored.²⁵⁰ The CCM is depicted by the GFATM as a hub for “country-level partnerships,” “participatory decision-making” and “local ownership,” and except in exceptional circumstances, each GFATM applicant

²⁴⁹ Cohen (2005) documents the chain of events that led to the exposure of the GFATM mismanagement in Uganda: a representative of an anonymous Ugandan CSO emailed the Head of GFATM watchdog NGO Aidspace on 13th June 2005. That tip off was passed on to the GFATM, which sent a legal counsel to meet with the whistleblower a few weeks later. The GFATM then asked accounting firm PricewaterhouseCoopers to audit the \$26 million it had so far disbursed to Uganda. On 24th August, GFATM grants to Uganda were suspended based on the findings of that audit.

²⁵⁰ An explanation of the Country Coordinating Mechanism (and other GFATM entities) is outlined in box 8, p141.

country is expected to establish one.²⁵¹ Yet, inherent to the GFATM conceptualisation of the CCM is a profound contradiction: while countries are permitted to adapt the CCM model according to national preferences – in order to create “ownership” – they are nevertheless strongly encouraged (or is that mandated?) to include non-governmental players as equal partners in their designs.²⁵² It is a contradiction the GFATM has itself identified:

“Since the inception of the Global Fund, a programmatic tension had developed between the Global Fund’s focus on principles, which stipulate, among other things, that countries should determine how they will manage their own processes...and the need expressed by key stakeholders involved in these processes for more guidelines and regulations to avoid malfeasance by those looking to benefit from involvement with the Global Fund at the expense or exclusion of other groups” (GFATM 2007a: 29).

The importance of ensuring CSO inclusion has been felt so strongly on the GFATM Board that there has even been talk of issuing penalties for countries that refuse to comply:

“Requirements alone may not be able to guarantee the effective participation of civil society (including vulnerable and marginalized groups) in Global Fund processes, unless they are enforced and unless consequences exist for CCMs that do not comply. Therefore, the Global Fund must decide how it can continue to encourage countries to determine the operation of their CCMs – maintaining country ownership – while at the same time upholding the principles embodied in the *Framework Document* [GFATM 2002] which explicitly highlight the importance of having a range of partners fully involved in its processes” (GFATM 2007a: 32).

In short, the GFATM’s fervent promotion of CSO involvement in CCM structures has more than a ring of aid conditionality. This is further evidenced in the guidelines

²⁵¹ <http://www.theglobalfund.org/EN/apply/mechanisms/> [Accessed 18/10/08]. In extenuating circumstances a Non-CCM proposal can be submitted. “Reasons include political or environmental instability, or because the populations implicated may be criminalized or persecuted” (GFATM 2007a: 34).

²⁵² Interestingly the GFATM won’t allow that the inclusion of civil society in CCMs is a condition precedent (CP). Instead it stipulates that while the following are “not really conditions precedent. They must be met before the TRP can review the proposal, but they are not CPs to the grant.” These include: 1. CCM members representing the non-government sectors must be selected /elected by their own sector(s) based on a documented, transparent process, developed within each sector, and 2. All CCMs are required to show evidence of membership of people living with and/or affected by the diseases (GFATM 2009: 5).

and minimum requirements the GFATM has established for CCMs. Thus one learns that “The CCM was designed to mirror the structure of the Global Fund Board” (GFATM 2007a: 29), where CSO participants should have full voting status and comprise 40% representation, and find that three out of the six Minimum Requirements set for CCM eligibility for funding would appear to mandate CSO participation. These require that CCMs exhibit a “Transparent selection process for CCM Membership of non-governmental members,” “Membership of persons affected by HIV/AIDS, TB and Malaria,” and “Ensure the input of a broad range of stakeholders” (GFATM 2008a).

The issue centres on that persistent neoliberal view of the nation state highlighted in the opening paragraph. This suggests that states can neither be relied upon to guarantee adequate public services for their citizens, nor now be trusted to spend aid funds in a scrupulous and transparent manner.

The sixth minimum requirement of the CCM states that “When the PRs and Chair or Vice Chair(s) of the CCM are the same entity, CCMs must have a conflict of interest plan” (GFATM 2008a). That the national government would hold both seats is clearly not the outcome desired by the GFATM. The inferred ideal is to have a vice-chair from a non-governmental body. Yet even with CSO representation, the role the state plays in CCMs continues to be problematised in GFATM discourse:

“the national government has a powerful voice in CCMs and in country-level Global Fund processes. Given the strong representation of government in many countries, some groups – civil society in particular – may feel too intimidated to express their perceptions. In cases where they are expressed, the uneven balance in representation may affect whether or not these views are considered” (GFATM 2007a: 34).

In short, it would appear that what the GFATM is envisioning through its multi-stakeholder CCMs is a dilution of state power. What I find noteworthy is that it is a lack of cohesion within civil society – rather than qualms over national sovereignty – that is portrayed as the single biggest impediment to achieving this end. As such, CSOs are advised to “coordinate and develop networks to increase their

representation within these processes” (HIV/AIDS Alliance & GFATM 2008: 5). Clearly the potential power of coordination groupings – which ostensibly improve sub-group participation in national processes – is not lost on the GFATM. Thus it is the rhetoric of ‘coordination’ - and its associated terms ‘partnership’ and ‘participation’ - which serve to mask the tacit purpose behind the GFATM’s objective to ensure civil society representation in its CCMs: its desire to offset state power through the realisation of participatory democracy. That the democracy it extols may need to be imposed top-down, signals the pragmatic modification the Fund is willing to make to its definition of country ‘ownership’ for the greater good.

Later in this chapter, I shall outline how certain CSOs in Uganda are currently heeding the GFATM’s advice to coordinate in a bid to strengthen their voice now they have been invited to join the discussion table, in addition to highlighting some of the factors which may still impede their ability to act as an equal partner vis à vis the Uganda nation state. Before doing so however, it is useful to clarify exactly what concessions civil society is now, in theory, entitled to enjoy as a consequence of the GFATM’s influence in Uganda.

The Long-Term Institutional Arrangements and Civil Society

The LTIAAs are a set of practical guidelines for the management of development aid in Uganda. They are the product of a broad stakeholder consultation undertaken in the country following the GFATM’s suspension in 2005, and are a reminder of the country’s ongoing efforts to rebuild donor confidence following the scandal.

The overriding principle of the LTIAAs is “the realignment of all funding mechanisms to existing institutional arrangements...” (Doc 1. 2006: 5). As such, it was been decided that two existing coordination fora - the Health Policy Advisory Committee (HPAC) and the Partnership Committee of Uganda AID Commission – will come together to subsume the role of CCM for Uganda, with the HPAC concentrating its efforts on the TB and Malaria grants, and the Partnership Committee on the HIV/AIDS grants (this division of labour is fully elucidated upon in Chapter Four). This arrangement is in stark contrast to what went before, when the CCM was a

parallel body, dislocated from the state apparatus and dedicated solely to GFATM business. At this point I should impress that I will be concentrating solely on the ramifications of the new CCM arrangement for the HPAC forum. This is because the HPAC is a forum dedicated to operationalising the health SWAp in Uganda, while the composition and focus of the Partnership Committee reflects Uganda's multisectoral approach to HIV/AIDS, which is beyond the scope of this thesis. Accordingly, an important stipulation to note within the new LTIA is that membership of the HPAC forum should be expanded to include civil society representation for the first time.²⁵³

Other LTIA-derived concessions relating to CSOs include the potential to appoint a second Principal Recipient (PR) from civil society to manage non-public GFATM grants, a CSO holding the position of Vice-Chair within the CCM and the development of the 'The Civil Society Fund' (which is addressed in the next section of this chapter).

A cursory glance at the above synopsis would appear sufficient to satisfy any interested parties that the LTIA is a Uganda 'owned' initiative and that the resultant concessions the government has made to civil society have been voluntary. However, in view of the GFATM's stance regarding non-governmental representation in CCMs it is surely wise to dig deeper. The point is not to reach a definitive conclusion over whether the state's hand was forced or not. It is stimulated solely by the fact that prior to the adoption of the LTIA, civil society was excluded from the HPAC. And here, I need to make a distinction, civil society *had* enjoyed representation on Uganda's earlier CCM, but this had been as a member of a parallel body, established in line with the GFATM's original preference to have a Project Management Unit oversee its grants to Uganda. Moreover, the value of that representation was questionable given that the Ugandan government had handpicked

²⁵³ In this discussion I am making a distinction between civil society organisations and Uganda's three religious Medical Bureaus (or Faith-Based Organisations), which already held seats at HPAC prior to its adoption as CCM. The Bureaus provide what would be traditionally termed *mission* services and have a distinct status in Uganda as private not-for-profit (PNFP) health care providers. This is signified by the fact that they receive government funding to subsidise their services. Another way of distinguishing the Bureaus is to say that, unlike CSOs, the Bureaus do not operate in project mode. They have their own health delivery infrastructure and are permanently based in Uganda.

the members (Donoghue *et al.* 2005). Donoghue *et al.* (2005) explain that while Uganda's original CCM had originally consisted of 15 members, it had nearly doubled in size by April 2004, and now included three representatives from civil society and one from the private-for-profit sector. Their study points out that the Ugandan government actually boycotted the initial meeting held by civil society to discuss the GFATM. Moreover, that once the different partners did come together, there was tension between the government and CSO representatives over how the budget would be shared. To sum up therefore, civil society remained excluded from the "negotiation process proper" (Jeppsson 2002: 2059) in Uganda until the adoption of the LTIA's, meaning the newest incarnation of the CCM could feasibly be depicted as something of a Trojan horse.

A Working Group was set up in Uganda in January 2006 to aid the process of developing the LTIA's. Chaired by the Ministry of Finance, Planning and Economic Development (the MoFPED is Uganda's Principal Recipient for the GFATM), the group included representatives from Uganda's ministries of Health, Labour, Gender and Social Development, from the Uganda Aids Commission, from the donor groups – the Health Development Partners and the AIDS Development Partners – and from civil society. A logical and representative grouping of Uganda's health stakeholders, it is nonetheless significant to this discussion that civil society was represented in the LTIA's deliberations from the outset.

Throughout their deliberations, a major focus of the Working Group was to "maximize the potential of civil society in achieving national objectives..." (Doc 1. 2006: 7). As such, salient questions were posed, including "What are the advantages and disadvantages of appointing an additional PR for civil society, in addition to maintaining the MoFPED as the public sector PR?" (Doc 1. 2006: 7), and "How can genuine engagement of all stakeholders, in particular civil society in decision making bodies for health and HIV/AIDS responses be strengthened?" (Doc.1 2006: 9). Initial recommendations included: the selection of a second Principal Recipient for CSOs and the private sector, that resources passing through this channel would be off-budget, and that existing coordination structures in the health sector and AIDS

Partnership should be extended to enable the “active engagement of Civil Society at national level as members of policy-making bodies...” (Doc 1. 2006: 27). A final caveat to the Working Group’s initial recommendations was that an interim funding arrangement should be devised until such a time as a second PR for civil society could be appointed.

The GFATM’s Minimum Requirements for CCMs were addressed in the last section. In developing the LTIAAs, Uganda carried out an assessment of HPAC against the Minimum Requirements, highlighting how it fulfilled each of the conditions. Thus for example, in the 2006 assessment one learns that the CSO Steering Committee “has been reminded” to use the principle of having persons affected by HIV/AIDS, TB and malaria as members of the CCM when selecting their HPAC representatives (Doc 3. 2006: 15); that Uganda has (in principle) opted to have two Principal Recipients; and that the conflict of interest requirement was not deemed applicable to Uganda because the CCM Chair and Vice-chair have been appointed from different ministries - Finance and Health respectively (Doc 3. 2006).

It was interesting in 2007/08 to assess how the Minimum Requirements had been actualised at the country level. Subsequently, I found that a very literal translation of the requirement to have persons affected by the diseases in membership had been achieved in Uganda whereby “All the 3 representatives of civil society organizations sitting in HPAC are persons living with the diseases” (Doc 4. 2007: 9). I also discovered that a second Principal Recipient from civil society has still not been appointed and in fact the very idea seemed to have been put on the back burner. When I asked about this in an interview at the Ministry of Finance, I was told that although there was still a tentative plan to proceed in this direction, civil society was yet to “mature” and that the second PR idea was now something that might “possibly” happen “eventually” (MoFPED Interview 25th April 2008). Indeed, to all intents and purposes, it is the new ‘Civil Society Fund’ (addressed in the next section) that is fulfilling the second PR function in the meantime. Finally, I found that there had been an objection from the GFATM to the suggestion that two representatives from the Government of Uganda would hold both Chair and Vice-

chair seats at the CCM and as a result, one of the civil society representatives to gain HPAC membership had since been appointed Vice-Chair.

What then does the early implementation of the LTIA in Uganda tell us about state and/or GFATM influence in Uganda's health sector?

The Ugandan state has certainly been persuaded to make structural changes which – at least superficially – appear to benefit civil society yet it is nonetheless clear that it has negotiated these compromises at every turn. Hence, the idea of a second PR is agreed in theory but distinctly on hold, a CSO representative is Vice-Chair of the CCM but this was not the GoU's first choice and time will tell how much influence she can wield; and yes, CSO representation was permitted to the HPAC for the first time but the state employed a 'two bird, one stone' tactic to circumvent the need to have additional CSO members living with the disease. In short, just as the potentially radical health reforms of the 1990s were seen to be quietly compromised in Uganda, in 2007/8 moderate adjustments were already being made to the LTIA, indicative of the state's unwillingness to relinquish its dominance over the health sector. That is not to say that the concessions it has made to CSOs are not substantial. For instance CSOs, together with the Faith-based Organisations and the private sector now hold 6 out of the 17 votes at HPAC (Doc 4. 2007: 7), where, I should underline, CSOs are now full members (regardless of whether the forum is performing in its new role as CCM for the GFATM or in its traditional role as a policy advisory body for the sector). But the concessions are nonetheless ring-fenced. Lest one should forget, civil society now holds 6 out of the 17 votes within an *advisory* body, and not a decision making one. And as I shall establish toward the end of this chapter, the power to veto is still one monopolised by the state.

In order to examine GFATM influence in Uganda with regards to the LTIA, the context into which the LTIA was delivered first needs to be stressed. GFATM grants to Uganda were suspended in August 2005 following reports of mismanagement. Prior to that point, the Ministry of Finance was the Principal Recipient, the Ministry of Health was the Executing Agent and a Project

Management Unit implemented the grants. It was the disjuncture between these different bodies that created the circumstances for mismanaging the money.²⁵⁴ The GFATM suspension was subsequently lifted in November 2005 when it was agreed new institutional arrangements would be devised through a “broad consultation involving all stakeholders” (Doc 1. 2006: 4). That the GFATM was able to persuade GoU to undertake this “broad consultation” is hardly surprising given the importance of GFATM money to the national health budget, and in light of the government’s open admission as to the failings of the previous working arrangement. Moreover, in the context of the earlier gross mismanagement of its grants, it is rather logical that the GFATM would subsequently prefer to have civil society presiding as ‘watchdogs’ over grant processes on the ground.

Whether the GFATM could have actually *mandated* civil society participation in Uganda’s CCM at this time remains a contentious issue – unresolved even at the GFATM Board level (at least in 2007) – yet it seems unlikely that it would have needed to do so in this case. With regards to Uganda, I would suggest that yes, the idea to invite civil society to join the CCM/HPAC originated from the GFATM.²⁵⁵ Indeed a top MoH official confirmed this during an interview, acknowledging, “Global Fund was more comfortable having those [civil society and private sector] in” (Interview 7th April 2008). However, given the extenuating circumstances, it is doubtful that the GoU was strongly opposed to the suggestion. As underlined in an earlier section, the Ugandan state is not averse to change or reform, no doubt because it is quite adept at circumventing threats to its central dominance. Furthermore, as I have sought to demonstrate with regards to the LTIAAs, the GoU has successfully met each of the conditions set by the GFATM, despite conceding very little in the way of power.

²⁵⁴ See Chapter Five for further explanation.

²⁵⁵ Again I would refer you to the GFATM discourse, which insists that the following are “not really conditions precedent. They must be met before the TRP can review the proposal, but they are not CPs to the grant.” These include: 1. CCM members representing the non-government sectors must be selected /elected by their own sector(s) based on a documented, transparent process, developed within each sector, and 2. All CCMs are required to show evidence of membership of people living with and/or affected by the diseases (GFATM 2009: 5).

The Civil Society Fund

Uganda's new 'Civil Society Fund' is recognised as an integral component of the LTIA and, as such, has attained the full backing of the GFATM: "Consistent with the GFATM principles, The Uganda Civil Society Fund (CSF) was designed to facilitate proactive and productive civil society involvement in the National HIV/AIDS response through public and private partnership" (Doc 4. 2007: 26). Yet, just as the LTIA has become the blueprint, not just for GFATM, but for all aid relations in Uganda, so the significance of the CSF now transcends GFATM funding to encompass a range of multilateral and bilateral inputs for HIV/AIDS activities.

Cognisant of its Paris credentials (in particular the harmonisation principle), the CSF is being promoted as a basket funding mechanism intent on coordinating development assistance to CSOs engaged in HIV/AIDS interventions in Uganda. Its guiding principles include: alignment with national policies; transparency and user friendly processes; rapid disbursement of funds; addressing critical gaps in the national response; effectiveness and efficiency; capacity building at all levels for sustainability; and partnership between civil society, donors and government (Doc 2. 2006: 43).

Although still in its infancy, the GFATM and Health Development Partners are already watching the Fund intently to see if it could be expanded to encompass tuberculosis and malaria funds as well.

There are several aspects of the CSF's development and operating model that made it interesting to this, a discussion of a proposed attempt to dilute state control in Uganda's health sector through the promotion of increased civil society participation. Common to them all is strong donor backing, and an avowal that coordination – be it of funding, or CSO activity – has the ability to increase the efficacy of the HIV/AIDS response in Uganda. I shall address these issues shortly. First however, I would underline what has been conspicuous in the development of the CSF by its very absence: at no point has there been any suggestion that the basket fund (which is

designed to bypass the state budget) might be incompatible with Uganda's sector-wide approach in health. Thus while there are plenty of assurances as to the CSF's alignment with national strategic plans, there is no comment on the fact that government structures are being actively bypassed by the Fund's *modus operandi*.

The concept of developing a basket fund for HIV/AIDS was developed by the AIDS Partnership in Uganda. This is a broad coordination network encompassing the Uganda AIDS Commission (UAC), salient UN agencies, bilateral donors, people living with HIV/AIDS and representatives from civil society, the private sector, scientific bodies and academia. In spite of the diverse range of stakeholders involved in the Partnership, it is significant that it was actually a USAID/PEPFAR-funded programme - Core Initiative – that inspired the CSF's operating model.²⁵⁶

Core Initiative had already been working on a pooled funding mechanism to strengthen civil society's engagement with orphans and vulnerable children through the Social Development Partnership Fund when the CSF was being discussed, and it is three key features of this model that have been incorporated into the CSF design with very little alteration (Doc 4. 2007: 44 & 52). I shall introduce these now in turn.

The first feature of the Core model to be adopted was the appointment of a Steering Committee, made up of different stakeholders to provide overall strategic guidance for the Fund. The composition of the CSF Steering Committee is as follows: two representatives from the Uganda AIDS Commission, one from the Ministry of Health, one from the Ministry of Gender, Labour and Social Development, two AIDS Development Partners and four civil society representatives (including one from the private sector) (Doc 4. 2007: 45). The composition of the Committee is remarkable because even if the representatives from Uganda AIDS Commission are counted as 'government' officials, the fact is the 'government: non-governmental' ratio on the committee stands at just 4:6.²⁵⁷ In short, there is not even an equal

²⁵⁶ Core Initiative is a USAID-funded global programme aimed at improving community and faith-based responses to HIV/AIDS through grants, capacity building and networking. <http://www.coreinitiative.org/> [Accessed 24/10/08].

²⁵⁷ Uganda AIDS Commission is in fact a semi-autonomous body situated under the Office of the President. It was established in 1992 to plan, oversee and coordinate Uganda's multi-sectoral response

balance of government representation on the Steering Committee of a Fund intended to strengthen Uganda's national response to HIV/AIDS.

The second notable feature of the Core Initiative model adapted for the CSF is a tripartite management structure whereby non-governmental organisations are contracted to assume the following roles: Financial Management Agent (FMA), Technical Management Agent (TMA) and Monitoring and Evaluation Management Agent (MEMA). The idea is that each of the management agents has a very specific mandate, which includes providing support to grantees according to their particular expertise (e.g. one appointment by May 2008 had been the international accounting firm Deloitte and Touche as TMA). It is this central capacity-building role that constitutes the third component of the Core model taken up by CSF.

A long-term objective to improve the capacity of CSOs is central to the ethos of the Fund, and another way in which its principles mirror those of the GFATM. This is demonstrated by the set up of Regional Agencies to disseminate support to CSOs at the district level, and the fact that even unsuccessful CSF applicants will be offered constructive feedback in order to improve their chances of success in subsequent funding rounds (WHO Interview 15th November 2007).

In the battle against Uganda's HIV/AIDS epidemic, the weak capacity and fragmentation of CSOs has been portrayed as a stumbling block (Doc 4. 2007). Significantly, it is those same factors which the GFATM has identified as weakening CSO representation vis à vis the nation state. It is striking therefore, that an overt objective of the CSF to raise CSO capacity for the HIV/AIDS response could also have a secondary effect: potentially improving the capacity of civil society to better negotiate with the Ugandan government.

to HIV/AIDS. <http://www.aidsuganda.org/> [Accessed 24/10/08]. As outlined in the 2001 Poverty Eradication Action Plan, such institutions "are responsible to Government but have some freedom to take executive decisions" (MoFPED 2001: 11).

I mentioned earlier that the GFATM is just one of the funding sources being channelled through the CSF. Other donors to it include: DFID, Irish Aid, Danida and USAID/PEPFAR (USAID Interview 30th April 2008). As such, the volume of aid the CSF has already attracted is substantial - a recent suggestion in the Ugandan press put the figure at Ugandan Shillings 50 billion (Daily Monitor Reporter 2008), which is approximately US \$25 million.²⁵⁸

USAID/PEPFAR has already assigned US\$8.1 million to the Fund (USAID Interview 30th April 2008), which is a bit of a coup considering the US's congressional constraints over aid allocation. Indeed, USAID/PEPFAR's role in the CSF deserves further mention. Not only did one of its programmes provide the template for the operational model, there is now the potential that it will be responsible for contracting and overseeing all three of the management agents employed to manage the fund; not that this is at the behest of the other donors however. A USAID interviewee was able to tell me something of the behind-the-scenes wrangling that has occurred during the CSF negotiations which go some way to exposing the myth of seamless stakeholder coordination on the ground.

While the CSF Steering Committee was happy that USAID should oversee the FMA and TMA, it was against USAID having the responsibility for contracting the Monitoring and Evaluation Management Agent as well – the fear being that this would mean USAID would be “in charge” of the Fund (USAID Interview 30th April 2008). However, regulations specific to the other bilateral donors means that they are not permitted to assume the role; for instance, Irish Aid cannot contract independently and must do so through the GoU, while Danida isn't allowed to fund Monitoring and Evaluation in country.²⁵⁹ A final caveat to the debate over the third management agent relates to why USAID/PEPFAR money has been allowed into the CSF in the first place. USAID is unable to channel aid via other donors. It is however, permitted to contract non-governmental agencies directly. Therefore as

²⁵⁸ The newspaper article failed to specify the time period over which the money would be distributed. The CSF grants will be performance-based and only granted for one year at a time. Therefore it is unlikely that this figure is what the CSF would allocate annually.

²⁵⁹ DFID's inability to take on the role was attributed to its global reorganisation.

long as USAID is the donor who contracts the management agencies it can put PEPFAR money into their pot. Indeed it is this stipulation that has complicated the case further, as USAID wouldn't actually be permitted to contribute to the monitoring and evaluation of the CSF if not appointed lead donor for that agent. The current state of play in 2008 was that USAID would oversee all three management agencies, although much to the chagrin of the other donors (USAID Interview 30th April 2008).

An interview at USAID (USAID Interview 30th April 2008) suggested that even discounting the above dispute, the stakeholders involved in the CSF haven't coordinated well, largely due to inefficiency and poor internal communication. One telling comment was that their aim to present one common position to the government hadn't been achieved consistently, and that there had been instances whereby the UAC and local governments had attempted to divide and rule the donors in order to get their own way. Even now that the CSF is up and running, it is reported that disagreements persist over how the Fund will be managed in the longer-term. Yet despite the problems, the USAID interviewee maintained that the CSF remained a great concept and pragmatically allowed that: "anything involving multiple partners is always challenging" (USAID Interview 30th April 2008).

Such comments are enlightening and belie naive assumptions about the cohesion of development partners (Walt *et al.* 1999b). The heterogeneity of Uganda's health stakeholders' is discussed at length in Chapter Four so I won't dwell on the subject here other than to reassert my understanding that even the idea of a cohesive 'nation state' is problematic. As Chapter Four demonstrated, the problem with 'coordination' – as advocated in aid effectiveness discourse – is that it is incredibly difficult to do. So even though Uganda's donors may agree in principle that increased CSO participation in Uganda's health sector would contribute positively to the country's governance ratings, their own lack of cohesion is a potential impediment to the ideal. That the state regards dissonance as a weakness to be exploited is aptly demonstrated by the 'divide and rule' tactic attempted by the governmental stakeholders during the CSF negotiations.

I have already mentioned the donors who have chosen to participate in the CSF, and highlighted the central role USAID has, and is continuing to play, in its development. It could be that the US – indeed the biggest proponent of using CSOs or ‘implementing partners’ in project mode – is starting to subtly influence the way other donors function despite their outward criticism of it.²⁶⁰ Speaking about basket funding as a modality (and not about the CSF in particular) a Danida representative expressed why he supported it:

“I’m all for Basket Funding, you can hear that. I feel that because of the weakness here [Uganda]... you know you always get concerns in terms of agreeing to general budget support or sector budget support or whatever else we call it. But as far as I’m concerned there’s a lot of territory between that and the old traditional kind of project support... I mean you don’t have to jump from crawling to flying. You know there are a few steps in between, which I think are beneficial in actually going through and making sure we have a clear dialogue between the donors and the government. And there are good guys and there are bad guys within the Government as everywhere else. And if you like to, you know, give everyone the benefit of the doubt, I think you should also strengthen the hand of those with the right intentions. And if you give too much then you can give a lot of rope for people to hang themselves in, which to some extent is what happens” (Danida Interview 7th May 2008).

It seems that the issue uniting both support for basket funding and for a greater role for civil society is that of governance then, or rather residual concerns within donor circles as to how much trust can be put into the Ugandan government.²⁶¹ From this standpoint therefore, the CSF has additional value as a risk mitigation strategy.

The USAID operating model has in no doubt been heavily influenced by Congress’ long-standing and open distrust of aid recipient countries; views that it has maintained in spite of the political correctness inherent to modern ‘partnership’ rhetoric. Resolutely risk-averse therefore, USAID has already developed effective checks and balances to manage its aid at the country level. Moreover, Phase One of

²⁶⁰ USAID uses the term ‘implementing partners’ to describe the CSOs it contracts. It uses the additional terms ‘prime’ and ‘sub prime’ to illustrate whether it has contracted a CSO directly or whether this has been done through a CSO broker.

²⁶¹ For an explanation of basket funding see box 1, p23-24.

the PEPFAR programme (the *emergency* phase) has refined the USAID model - basically ensuring the donor agency's metamorphosis from implementing agency to "wholesaler of wholesalers" (Brainard 2007: 47; also see IOM 2007).²⁶² In the era of 'good governance' and with aid resources for the 'big three' at an all time high, it's just possible that the US aid model will emerge as the exemplar for donors wanting to divert increased funding to civil society.

It should be remarked however, that not all of Uganda's Health Development Partners have as yet signed up to the CSF. An example of this, SIDA, would prefer to carry out a thorough assessment of the Fund in operation before deciding whether or not to partake. When asked what reservations it might have, an interviewee at the organisation replied:

"I'm not sure if it's really effective... There's a lot of donors that are putting money in there and it's a lot of funding, and all of a sudden I think, wait a second, it's a lot now, is it really the right way?...I just feel I really need to look through the civil society fund, how it's organised, how it's functioning. And is that really something we believe in? That type of work? I mean it's all new and no one really knows what will be the outcome...I don't know if the workload will be less. I feel harmonisation has meant much more work ...But I don't know, it could also be a trend" (SIDA Interview 22nd May 2008).

The SIDA comments highlight a central characteristic of modern aid initiatives: a lack of empirical grounding.²⁶³ Recalling the disconnect between development plans/policy and outcomes identified by Ferguson (1990) and Mosse (2005), and the Walt *et al.* comment that "there may be unexpected consequences from the introduction of new aid instruments aimed to improve coordination..." (Walt *et al.* 1999b: 279) the SIDA representative would prefer to see what happens with the fund before deciding whether to sign up. Here then is an experienced development professional not entirely convinced of one of the key selling points of basket/pooled

²⁶² Here, I refer to the USAID practice of contracting out large-scale projects to CSO and private sector implementing partners (typically large US or international organisations), who then sub-contract that work out to multiple smaller partners in the field. Brainard suggests this growing practice is "both cause and consequence of diminishing personnel and field presence" for the donor agency (Brainard 2007: 47). Please see Chapter Six for an explanation of the PEPFAR's two phases.

²⁶³ This need not even be a critical comment if you agree with the school of thought that suggests that development aid by its nature is "experimental" (Riddell 2007: 178).

funds - that the CSF will reduce the workload for the participating donors. A second concern she expressed related to accountability: "I feel like the Civil Society Fund, my money...Huh my money...My money is going through the fund and then all of a sudden we're there with all the...ah! I just feel that needs a lot of monitoring also." (SIDA Interview 22nd May 2008). In short, for this SIDA representative, another extolled advantage of the CSF remained in doubt.

In terms of monitoring the use of money channelled through civil society, Uganda's CSF donors could yet come to regret their current haste to adopt a PEPFAR-style model of contracting. To date the transparency of the PEPFAR programme has left a lot to be desired, leading to serious concerns about the proportion of PEPFAR funds being expended on CSO overheads (Oomman *et al.* 2007). Moreover, the situation got so bad with regards to the PEPFAR programme in 2006, that the aid initiative was forced to admit it had lost track of some of its funding - a situation blamed on the logistical nightmare of tracking funds through proliferating numbers of CSO partners, with many not yet able to meet the programme's exacting reporting requirements (Washington Times Reporter 2006). Yet questions over the value for money aspect of using CSOs in service delivery extend far beyond PEPFAR's funding. In Uganda, one study has suggested that up to 70% of CSO funding is currently spent on administration (Nabyonga *et al.* 2009: 8). Such a figure is surely irksome to any national government that now finds itself in direct competition with civil society for funding.²⁶⁴ It also points to a double standard in development whereby governments are being subjected to relentless financial scrutiny over the aid they receive, while civil society organisations are being given - at the very least - enough rope to hang themselves with.

The uncertain empirical grounding of Uganda's Civil Society Fund also throws up questions about how the CSOs that implement its grants will be affected. Thus in the case of the CSF, the *anticipated* outcomes include improved CSO capacity and better

²⁶⁴ Uganda's country study on the implementation of the Paris Declaration found that: "New developments in aid architecture in Uganda are seen as prioritising private sector and NGO channels of delivery over and above government institutions" (Office of the Prime Minister 2008: 22).

alignment to national plans, but what might the “unexpected consequences” be? (Walt *et al.* 1999b: 279).

Donoghue *et al.* (2005) remarked that CSOs in Uganda were already employing additional staff to try and capitalise on GHI funding opportunities as far back as 2005, while Oomman *et al.* (2007) have commented on the immense pressure now facing USAID/PEPFAR to find enough CSOs to channel escalating PEPFAR monies into (originally USAID/PEPFAR had drawn on CSOs with a track record of pushing money out quickly, but it has now exhausted that supply and is always on the hunt for new partners).²⁶⁵ USAID/PEPFAR has pioneered the competitive bidding process and this is the model being adapted for the CSF. Subsequently, it appears that CSOs will face two types of threats from engaging in such a process: the cost of failure – should their scarce resources be invested in a failed proposal – and/or a distortion of organisational mandate.²⁶⁶ With regards to the latter, I would propose that one potential side effect of the CSF could relate to the exacting criteria of the Fund’s Request For Applications (RFAs). To provide some examples: one RFA posted in Uganda’s press in May 2008 called for CSOs engaged in HIV/AIDS prevention to target specific areas identified in the *National HIV & AIDS Strategic Plan’s* Comprehensive Package (UAC 2007); another was aimed solely at: “strengthening district level provision for orphans and other vulnerable children” (both were published in the Daily Monitor on 19th May 2008, p24). Faced with such restrictive RFAs, I would theorise that some CSOs - previously engaged in a wide range of health interventions – might opt to limit their remits in order to secure funding. Yet if this were to happen, would externally exposed specialisation in the pursuit of one- to three-year grants really benefit Uganda’s health CSOs in the long-term?

²⁶⁵ USAID/PEPFAR originally favoured international CSOs during PEPFAR Phase I, but has since increased its emphasis on using (and building the capacity of) indigenous CSOs. Indeed the PEPFAR evaluations explains that “Country teams are evaluated on the basis of the number of new and indigenous partners they are bringing into the program, and OGAC [Office of the US global AIDS Coordinator] has policies to limit the proportion of a Country Team’s budget that can go to any one partner...” (IOM 2007: 253). PEPFAR’s ‘New Partners Initiative’ is a concrete example of how the US has come to prioritise indigenous civil society. <http://www.pepfar.gov/c19532.htm> [Accessed 03/05/10]

²⁶⁶ This idea of having to invest scarce resources to win new aid funding is explored in depth in Chapter Five with regards to the Global Fund to AIDS, TB and Malaria.



Uganda AIDS Commission Civil Society Fund



Request For Applications (RFA) #08-001: HIV Prevention

The Uganda AIDS Commission's Civil Society Fund seeks to effectively harmonize and coordinate multiple donor resources for grants to civil society organizations supporting Uganda's National Strategic Plan for HIV/AIDS. This solicitation focuses on efforts to reduce HIV infection. With applicants responding to this solicitation, the CSF will support a program to expand targeted HIV Prevention services in Uganda through an extensive and substantial partnership with civil society. The CSF anticipates awarding grants to civil society partners expanding the availability and quality of integrated and comprehensive approaches to HIV prevention.

During this round, the CSF anticipates awarding approximately 25 grants totaling 2.7 million US dollars the first year. Individual grants will be supported for up to a two (2) year period beginning 01 November 2007, and may be for up to US\$ 200 million per year. In this round, the CSF anticipates supporting grants for programs that have the general goal of reducing the risk of HIV infection and that target the following areas of intervention:

- Prevention of sexual transmission of HIV, focusing on:
 - Young people
 - High risk groups
 - Adults in married or long-term sexual relations

Under this solicitation, the CSF will accept and review proposals from national and district NGOs, faith based organizations, and other members of Uganda civil society that meet the following criteria:

1. **Applicants must have been legally registered before 01 November 2005, and have a current registration.**
2. **Applicants must have at least two years of experience successfully providing HIV prevention services, and provide their most recent annual program report**
3. **Applicants must provide their most recent audited financial statement or certified annual financial report**

Applicants are advised that the CSF expects proposals from civil society partners with the institutional capacity and experience to absorb the management and administration of a large grant, and be operational at at least a district level. The CSF anticipates releasing subsequent solicitations during the first quarter of CY 2008 to address the pressing need to support smaller grants at the subcounty and community level. Also, in subsequent rounds, the CSF will address other elements of HIV Prevention, as well as Care and Support, OVC, and Treatment.

Applications are due by 1PM, Friday October 19th, 2007. Interested applicants are requested to obtain the RFA from the CSF at the following address:

Uganda AIDS Commission Civil Society Fund
Plot 1-3 Salim-Bey Road, Ntinda, Nakawa Division
Kampala.

Applicants may also download the RFA from UAC's website: www.aidsuganda.org

Figure 4: Request for Applications – HIV Prevention – from CSOs wishing to apply for grants from the Civil Society Fund (Daily Monitor, 27th September 2007, p16)

Hulme and Edwards identify the availability of aid finance as the most obvious pressure facing non-governmental organisations for cooption:

“The acceptance of increasing volumes of foreign aid involves entering into agreements about what is done, and how it is to be reported and accounted for. This fosters an emphasis on certain forms of activity at the expense of others, on upward accountability...and on particular techniques and donor definitions of ‘achievement’ throughout the organisation. Not surprisingly as NGOs get closer to donors, they get more like donors” (Hulme and Edwards 1997: 8).

In this vein, it has been noted that “Official donors provide three times as much money for NGOs [non-governmental organisations] to carry out development and humanitarian projects and programmes on their behalf as they provide to support activities which NGOs themselves choose to implement” (Riddell 2007: 48). From this vantage point, any suggestion that the CSF has the potential to check state power or improve governance ratings is founded on a contradiction, as the comparative advantages for which civil society are praised are endangered by the very mechanism conspired to strengthen it. Left unchecked, this could prove to be a serious oversight in the Fund’s design.

The ideological appeal of coordination and harmonisation measures is proving a powerful force in international donor circles. With regards to the CSF, this has been evidenced by Uganda’s biggest health donors choosing to contribute to the Fund from the outset. Yet the Fund’s extolled advantages are subject to doubt and even the central notion driving the CSF (and the other initiatives addressed in this chapter), that civil society can somehow contribute to ‘good governance’, is open to challenge (Robinson and Friedman 2005; Court *et al.* 2006; Riddell 2007; Roy 2008; also see Heinrich 2007).

To sum up, in this section I have identified the ways in which the CSF could be viewed as attempting to mitigate state control in Uganda’s health sector through the use of a USAID/PEPFAR-inspired basket modality, designed predominantly to channel HIV/AIDS funds away from the GoU and into the safekeeping of Uganda’s civil society ‘watchdogs’. Yet despite the central role capacity building plays in the

CSF's operating model, two factors appear to mitigate its potential: a lack of empirical grounding - which fails to take into account the "unintended" (Ferguson 1990: 21) or "unexpected consequences" (Walt *et al.* 1999b: 279) of the new aid instrument - and a lack of cohesion between Uganda's health stakeholders, which has already been shown to present the GoU with opportunities to divide and conquer.

CSO Coordination

So far in this chapter I have focused on the ways in which the GFATM, the Health Development Partners and - to a lesser extent - the Ugandan state have facilitated a greater space for civil society in Uganda's health delivery and debating mechanisms, and considered whether the participation being offered them disguises a deeper purpose. I would now redirect your attention to the intended beneficiaries of the concessions to find out how CSOs are capitalising on the opportunities now available to them. Central to this part of the discussion is the shared Jeppsson and GFATM view that national processes are "a stage where power relations interact" (Jeppsson 2002: 2059). Subsequently, that it is "important for civil society organizations to coordinate and develop networks to increase their representation within these processes" (GFATM 2008a: 5).

At the time of fieldwork in 2007/08, CSO representation at the Health Policy Advisory Committee/Country Coordinating Mechanism (HPAC/CCM) was still a relatively new phenomenon – the civil society representatives joined in Spring 2007 – yet their presence had already elicited some strong reactions from established members. Complaints centred on three things: the CSO representatives' tendency to be issue- rather than sector-driven:

"They know only project mode of operation. And they have no experience whatsoever of what it means to run an institution day in, day out, 365 days a year for 50 years. They don't know that and so the quality of the input that they give to the HPAC is very shallow" (UCMB Interview 13th May 2008).

On their having - what appeared to be - a disproportionately loud voice in group discussions - one interviewee commented that the CSO Vice-Chair seemed to have the “ear of the Chair” (USAID Interview 13th May 2008), while a representative for the Faith-based Organisations complained, “Well our voice, we are together – the [Religious Medical] bureaus we represent 30% of the services delivered to the people – and we matter less than the most vocal of the AIDS activists” (UCMB Interview 13th May 2008).

The third criticism related to their organisational skills:

“They’re weak. They are represented but they – and I know this from themselves – are not sufficiently organised. They feel they need to have other forums where they can meet, just like we have with the Development Partners Group, to discuss their different views and come up with a joint leading point. They don’t need to feel the same about everything but they can also have a lead who takes in the views of different NGOs and CSOs and represents...They need to be much stronger in HPAC” (SIDA Interview 22nd May 2008).

Out of the different criticisms being levelled at civil society at the HPAC/CCM, it was the last one relating to their organisational capacity that resonated most strongly with the CSO representatives themselves. Indeed, that they appeared issue-driven and disproportionately voluble at the forums was likely a by-product of their lack of coordination and inexperience in the new setting. Keen however to build on the unprecedented opportunity afforded them to engage in meaningful participation at the national level, Uganda’s health CSOs were found to be working hard to amend their shortcomings.

In Chapter Four I addressed the manner in which Uganda’s Health Development Partners (HDPs) have chosen to coordinate themselves.²⁶⁷ Significantly, it is this model that the civil society representatives attending HPAC now aspire to emulate (I say ‘significantly’ because of course it recalls the Hulme and Edwards (1997) suggestion that the closer CSOs get to donors, the more they resemble them). CCM

²⁶⁷ The HDPs have created a separate forum in which to arrive at common positions, which they then communicate at HPAC through a lead donor. This creates the semblance that they speak with “one voice.”

Vice-Chairwoman (from civil society) described the HDP coordination model as a “beautiful example,” yet was realistic that it would be a challenging ideal for Uganda’s CSOs to emulate:

“They [the HDPs] are maybe about fifteen or twenty or so and we are thousands so we can definitely not fall into their shoes immediately. Our desire would be to move towards a more coordinated system like they have but given our diversity and our challenges we still have some steps to that” (MACIS Interview 24th April 2008).

The challenges facing Uganda’s health CSOs are fourfold: as with all civil societies they are “made up of many different groups, wanting different outcomes, often displaying conflicting values” (Walt et al. 1999b: 282); “They have similar harmonization issues to the Paris Declaration on aid effectiveness, at the ground level but with much more limited resources and forums to address them” (GFATM 2007b: 39); and they are “severely disadvantaged” when it comes to accessing technical assistance. (GFATM 2006: 21) Finally, there is but a scant tradition of CSO coordination groupings within the country to draw upon. As such it was perhaps no coincidence that the CSO representative elected as CCM Vice-Chairwoman had already had some experience of heading a CSO coalition, in this instance the Malaria and Childhood Illness NGO Secretariat (MACIS). Nevertheless the scale of that operation – coordinating around 70 CSOs engaged in malaria and child health activities – is unlikely to have adequately prepared her for the task ahead.

Given its advocacy for their participation, it is striking that the GFATM sends out a somewhat contradictory message to CSOs preparing to actively engage in national processes for the first time: thus while placing the onus firmly on CSOs to organise themselves - “Ultimately, the responsibility for increasing civil society engagement lies within civil society itself” (GFATM 2008a: 5) - it nevertheless advises that they strive towards an operational model of “representative democracy” (GFATM 2007a: 32). Yet how easy this is to achieve with a poor communication infrastructure and a constituency of thousands is questionable.

A recent example demonstrates how literally the Ugandan CSO representatives have interpreted the responsibility to represent their constituents. The example concerns a CCM meeting to discuss the Round 8 GFATM proposal, at which – one of the bilateral donor participants later conveyed to me with some exasperation - the CSOs had requested US \$500,000 to facilitate multi-tiered consultations around the country to feed into the civil society component of the proposal, yet had only allowed two weeks to conduct the consultation (USAID Interview 13th May 2008).

The problem of Uganda's CSOs realising the GFATM ideal of representative democracy is further compounded by an extended notion of who their constituents are. When asked what the CSOs wanted to achieve from their involvement within the HPAC/CCM, the CCM Vice-Chair replied:

“Our ultimate aim as civil society is to ensure that the voices of the mothers, of the children, of the communities where we work can be heard. These very good experiences, practices can be used to inform policy, so that when policies are made and debated they are based on reality in the communities” (MACIS Interview 24th April 2008).

In essence, this understanding of ‘constituent’ has enlarged the task of representing thousands (of health CSOs) to that of millions (of Uganda's health users), and of course this is exactly what the GFATM hoped the CSOs could bring to the policy table. Yet quite how three CSO representatives situated in Uganda's capital are to manage such a task is unclear. Let us remember at this point that they receive no additional salary for their participation in HPAC/CCM.

A final complication to the representative democracy ideal was presented by one of HPAC's original non-governmental members, the Executive Secretary of the Ugandan Catholic Medical Bureau (UCMB).²⁶⁸ Traditionally allied with Uganda's Protestant and Muslim Bureaus at the HPAC, he explained that the idea the three Bureaus should coordinate, or “try to speak with a united voice” at the HPAC, was

²⁶⁸ Earlier in this discussion we differentiated Uganda's Religious bureaus – or Faith-Based Organisations – from everyday CSOs, essentially on the grounds that they are permanently based in Uganda. They also differ in that they have attended HPAC since its inception and receive a government subsidy.

suggested recently – crucially by an external source - and was something that they were all immediately reticent about. That is not to say the three Bureaus haven't been willing to assume a common position in the past - "we try to keep the cartel compact because if we handle issues separately we are not going to have success" - but that they ultimately remain three separate organisations, subsequently "none of us can represent the other." He underlined the central flaw in the representative democracy ideal from the vantage point of the Bureaus:

"You sit at a table alone and then you have to take a decision or you have to decide to sign a document...and assuming you're representing the others, it assumes a structure of coordination, and or, consensus that does not exist. And the onus on creating this structure is left on us. Well it's a little too much, we have the onus of having everything because we don't get money from government or from development partners to do this kind of work" (UCMB Interview 13th May 2008).

While the CSO representatives at HPAC/CCM differ from the Religious Bureaus in their clear willingness to represent their counterparts, they have nevertheless found themselves in a similar bind: having to create an effective coordination mechanism so that they can arrive at common positions before they attend the HPAC/CCM, and having to do so retrospectively. Subsequently, one year after they joined the "negotiation process proper" (Jeppsson 2002: 2059) in Uganda, the CSOs announced their plans to rectify this deficiency. Speaking at the Mid-Term Review of *Health Sector Strategic Plan II* (MoH 2005) in May 2008, the CCM Vice-Chairwoman (from civil society) delivered a closing statement on behalf of Uganda's health CSOs, which included this salient detail:

"I have some good news, that a section of CSOs is taking up a leadership role and are presently working on a widely consultative strategic mechanism for improving coordination of CSOs involved in implementation of HSSP II. This is aimed at providing CSOs with an effective channel to galvanise our operations and will provide us with a channel for CSO voices to appropriate policy and decision making on issues of concern to CSOs at national, district and community level" (MTR Closing Remarks From Civil Society 29th May 2008).²⁶⁹

²⁶⁹ The Mid-Term Review was a three-day sector multi-stakeholder forum held between the 27th and 29th May 2008.

Still in its infancy, it will clearly be some time before it's possible to report back on the progress of the CSOs "consultative strategic mechanism." Yet that the CSOs have even considered it essential to attempt, shows that the value of arriving at one common position before attending the HPAC/CCM extends beyond one of sheer convenience. Like other processes involved in negotiating with the state, this discussion has demonstrated that there is power imbued in the act of arriving at a consensus with your peers. The Executive Secretary of the UCMB touched upon it when he alluded to the "cartel" the three Religious Bureaus attempted to keep "compact," and the development partners paid the price for not achieving it during the discussions for the CSF when their government partners attempted a tactic of divide and rule. The essential ingredient of effectively coordinating with your peers therefore appears to be masking difference to attain strength in numbers.

In this vein, it is interesting to note that at the 2008 Mid-Term Review, the CSO Closing Statement also included an overt declaration of support for Uganda's Medical Bureaus (which in this statement are referred to as PNFPs or Private Not-For-Profits):

"The efficient use of budget support by the PNFPs demonstrates that CSOs can be a truly reliable partner in the delivery of health services. We therefore continue to urge the Ministry of Health and Development Partner to look into the issues of funding CSOs including; stagnation of support to PNFPs; more streamlined engagement with the non-facility based CSOs and the Private Health Practitioners" (MTR Closing Remarks From Civil Society 29th May 2008).

This statement alludes to several key issues, which serve as further evidence that coalition building is viewed as a powerful strategy to improve group standing vis à vis the nation state. The first refers to the role of the PNFPs as key service providers in Uganda – they collectively own and manage 30% of Uganda's health services and have been established in the country for upwards of 50 years. The second refers to the Bureaus ongoing dispute with the GoU over the stagnation of their subsidies – in real terms subsidies to the PNFP have been decreasing by 10% annually for four years. I shall elucidate on these issues shortly but the point to highlight at this juncture is that in this statement – delivered at a sector-wide conference - the new

CSOs to HPAC/CCM can be construed to say, “We are the same as the Religious Bureaus. Like them we can be trusted to use resources efficiently. You should definitely consider channelling some money through us.” The suggestion however is a non sequitur – the CSOs differ from the Bureaus in *every* respect except their non-governmental status - therefore, that they have been allowed to make such a statement reveals the aspirations of both the CSOs and the Religious Bureaus to forge a mutually beneficial yet largely superficial alliance to advance their separate agendas. For the Bureaus, the alliance denotes just one in a long line of attempts to persuade the government of Uganda to increase their subsidies.

While this is predominantly a discussion of CSO engagement in Uganda’s health sector, the narrative of the Religious Bureaus and their attempts to resolve their funding problems with the GoU may still provide some insight into what CSOs can expect to gain from their promotion to the HPAC/CCM forums.

Two aspects of the PNFPs funding arrangements are salient to this discussion. Firstly, that in 1996 – suffering money problems – the Bureaus presented the GoU with a simple proposition: “If you help us we can continue. If you keep ignoring us you will soon have to invest quite a lot because you will have to substitute what we are doing” (UCMB Interview 13th May 2008). Secondly, that having agreed to provide the PNFP with a regular subsidy, the GoU asked whether the Bureaus would like their funds to be channelled directly or through the newly established decentralised system. The PNFP chose the latter in order to support the sector as a whole; it later transpired that they would be penalised for choosing this, the route of “moral authority.”

The Global Health Initiatives have proved detrimental to the PNFP’s funding arrangement with the government because they have contributed a lot of additional – yet earmarked funding - that has bypassed the centre’s budget and gone directly to the points of service delivery. The consequence has been to make the Ugandan government complacent about the PNFP, yet conversely very interested in civil society (which currently attracts extensive external funding). Remarkably, despite

their funding going down, the Religious Bureaus have so far avoided competing for GFATM money for fear of losing their government subsidy. They are reconsidering this position now, attempting to “calculate how much they do matter in HIV/AIDS, TB and malaria,” yet those are not easy figures for the PNFP sector - which has always taken the horizontal approach to health care - to disaggregate (UCMB Interview 13th May 2008).

The Health Development Partners have been loyal supporters of the PNFP and have repeatedly championed their cause.²⁷⁰ Nevertheless, the issue seems to have fallen off the agenda at the Health Policy Advisory Committee. Subsequently, the Religious Bureaus have pragmatically sought out new alliances and fora in which to lobby. Indeed, it was surely an astute move on their part to get on side with the CSOs, which, at least for the time being, have the ear of Uganda’s largest donors.

The narrative of the PNFPs seems to hold two clear messages for the CSOs *if* they choose to hear them. Firstly, beware development trends: if you’re out of favour with donors then you’ll likely be out of favour with government. So while the PNFPs have maintained the support of Uganda’s bilateral donors, they are still off the radar of Uganda’s biggest health funders - the Global Health Initiatives - and are thus not very high on the government’s agenda. Secondly, once your importance to the state has diminished, it may no longer matter very much that you hold a seat at the discussion table. Experience has shown that the Ugandan state has devised subtle ways of sidelining unpopular viewpoints. Subsequently, while the MoH openly renews its commitment to raise its funding subsidy to the PNFP at its annual health sector forum year after year, it has so far failed to honour its pledge.²⁷¹

²⁷⁰ The Bureaus are honorary members of the HDPs – they were originally invited as observers by Irish Aid and DFID – and can in fact be understood to be “HDPs” by virtue of the additional resources they bring to the health sector.

²⁷¹ The need to support the PNFP was carried over as one of the undertakings of the annual Joint Review Mission in 2007 for the third year in a row. The renewed undertaking stated: “Health Sector 2008/09 budget to cater for the close of the remuneration gap between PNFP and public health worker” (MoH 2007b: 6).

Qualifying Civil Society's Concessions

The ability of the nation state to circumvent divergent opinions is the final caveat to this, a discussion of the potential of civil society to dilute its dominance in Uganda. Several interviewees have voiced their concern that decisions regarding the health sector are being reached with little or no feedback to the stakeholders in the HPAC, suggesting that the golden age of the SWAp, and subsequently the HPAC, is over (UCMB Interview 13th May 2008; also see MoH 2008b).²⁷² Of course the Health Policy Advisory Committee – as the name signifies – is nothing more than an advisory committee, and in the organisational structure of the health sector, sits below the Top Management Committee of the Ministry of Health (TMC): a closed-door forum, which retains the right to veto any recommendations made below it in the chain. During the so-called “golden age” advice emerging from HPAC seemed to impact and create interchange between it and the TMC, yet now the resounding complaint is that decisions are not only being made in a seemingly arbitrary manner at this higher echelon but that no feedback is being received lower down the chain (USAID Interview 13th May 2008).

In short, the reduction of HPAC's influence appears to come at the very time that its membership has expanded. This at once suggests that the GFATM strategy to utilise civil society to check state dominance is not as yet without its loopholes, and adds weight to the argument forwarded in Chapter Four - that ‘coordination’ of the sort implied in the Paris Declaration is still viewed as a piecemeal check list from which all partners are guilty of picking and choosing. That said, the division of power, even within the GoU structures remains a complicated one and will have some bearing on the future of Uganda's health CSOs. To summarise the issue here: Uganda's Ministry of Health is widely criticised for being weak (both within government and by its Development Partners). A hangover from the mismanagement of the GFATM, when a lot of the top management of the MoH were sacked or suspended and its staff demoralised, the new management is still working to rebuild stakeholder and GoU

²⁷² The *Mid-Term Review Report* notes that: “There is an emerging view...that the earlier dynamism and effectiveness of the Uganda SWAp has begun to wane” (MoH 2008: xxii).

confidence. Insightfully, one Health Development Partner described the interim before the shake up as “rotting time” (BTC Interview 10th April 2008). In short, while the general consensus is that the top management staffing at the Ministry is now sound, the overriding feeling is still that: “The malaise [at the Ministry] is going away but it’s a long hill to climb” (BTC Interview 10th April 2008). This has resulted in the Ministry of Finance retaining a disproportionate influence over the health budget, which has in turn encroached on the ability of the Ministry of Health to set health priorities. Perhaps the biggest indication of this is that in Uganda the Ministry of Finance is the Principal Recipient for the GFATM; in most other countries it is the Ministry of Health. Another example sees the Ministry of Health work with the Ministry of Finance to develop the Sector Budget Framework Paper (which sets the priorities of the sector) only to find its input restricted by the volume of money Finance has already assigned it in the Mid-Term Expenditure Framework.²⁷³

Until the Ministry of Health regains the wider trust of the government, the Ministry of Finance will continue to wield an unbalanced level of influence over it. Moreover, now that the GFATM has agreed (in principle) to provide its aid as budget support to the Ministry of Finance (MoFPED Interview 25th April 2008) it is likely that the GFATM too will wield some considerable sway over the sector budget. Therefore, until such a time as the GFATM sees fit to revise its policy towards civil society, I would suggest that CSO representation will be guaranteed at Uganda’s HPAC/CCM.

However, quite what CSOs will actively get out of having this position remains to be seen. Until Uganda’s health CSOs resolve their organisational problems, it is likely that the issues they champion at HPAC/CCM will prove too numerous, too mixed

²⁷³ A country study on the implementation of the Paris Declaration in Uganda confirms this suggestion: “The only limitation is that the final budget allocations approved differ significantly year on year from those initially approved by the sectors in consultation with DPs [Development Partners], and the overriding influence of the Ministry of Finance, Planning and Economic Development and Parliament creates the impression that the budget formulation process only seeks to legitimise decisions already made at much higher levels than the sectors. This tends to erode the confidence of the sectors in their ability to influence budget allocations” (Office of the Prime Minister 2008: 40). Equally, the Mid-Term Review Report remarks on: “The reported decline in the quality of Budget Framework Papers, the lack of adequate consultation in BFP development and lack of transparency in the allocation of the approved budget...” and the manner in which: “the health budget is being heavily earmarked at MFPE level before it reaches MOH, leaving little room for internal reallocation” (MoH 2008: xxii-xxiii).

and too minute – in short, too like project objectives – to be taken seriously. That’s not to suggest however, that they won’t be heard. My own concern is that until civil society is better organised, its representatives will continue to be a disruptive force at the HPAC/CCM.²⁷⁴ In short, for CSOs to make a positive impact at the forum they need to streamline their position and to start tackling issues from the perspective of the sector-wide approach. The great flaw in the GFATM strategy for their inclusion however, is that neither of those measures are either necessarily achievable and/or beneficial to civil society in the long-term.

In their bid to dilute the centre dominance in Uganda’s health sector (in wanting to influence policy) the CSOs involved directly, and indirectly with the HPAC/CCM forums will be forced to make a trade off: between broader agendas, common positions and increased funding, and specialisation, diversity and financial independence. The greatest downside to this trade off is that the potential payoffs they’re chasing are far from guaranteed. Aside for the numerous logistical problems civil society will undoubtedly face attempting to build an effective coordination network, this study has highlighted two issues that could seriously undermine the ideal of meaningful engagement. The first recognises that the Ugandan state has grown adept at going through the motions in the pursuit of aid flows (thus a seat at the policy discussion table may not prove that important); the second acknowledges that the international development agenda is highly vulnerable to trends. Civil society’s biggest concern should be a contingency plan in case – whilst in the midst of the “negotiation process proper” (Jeppsson 2002: 2059) - it suddenly finds its own influence being diluted. Indeed, this is the warning implicit in development critique *Participation: the New Tyranny*, which draws on Wood (1999) and Cohen (1985) to impress the dangers facing the excluded when finally invited to participate:

“those people who have the greatest interest to challenge and confront power relations and structures are brought, or even bought, through the promise of development assistance, into the development process in ways that disempower them to challenge the prevailing hierarchies and inequalities in

²⁷⁴ Chapter Five confirms that multi-stakeholder forum, the HPAC, has already experienced serious disruption while subsuming additional duties as Country Coordinating Mechanism for the GFATM.

society, hence inclusionary control and inducement of conformity” (Kothari 2001: 143).

Conclusion

The drive for the greater inclusion of civil society in service delivery and policy deliberations in developing countries has been building momentum since the turn of the millennium, and is now firmly entrenched in the discourse on aid effectiveness – in the Monterrey, Rome and Paris commitments – and in the strategic plans of donors agencies, the Global Health Initiatives and aid-recipient governments.²⁷⁵ Such unqualified support has contributed to what is now the resilient depiction of civil society as a global public good (Riddell agrees that “most official donors remain content to continue to provide broad support to CSO- and NGO- strengthening efforts on the (unproven) assumption that it is a ‘good thing’” (Riddell 2007: 304). In Uganda this has translated into a series of unprecedented concessions for the country’s non-governmental health ‘partners’.

Yet there are several serious problems inherent to the current framing of civil society in development. The first recognises that a universal definition for what constitutes ‘civil society’ is lacking (Riddell 2007).²⁷⁶ The slippery terminology means that a ‘CSO’ can just as easily be a solitary man who runs his local football team as an international children’s charity or a US university. It says nothing about the

²⁷⁵ To provide some examples: 1. Uganda’s Joint Assistance Strategy states: “The government should continue to promote genuine government and civil society partnership in the context of PEAP implementation and monitoring” (UJAS Partners 2005: 10). 2. The *GFATM Framework Paper* states that CCMs should include broad representation, including from civil society; states the Fund’s intention to support programmes that: “Stimulate and are integral to country partnerships involving government and civil society” (GFATM 2002: 4); and articulates the Fund’s aim to “Strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals” (GFATM 2002: 3). 3. Volume 3 of the 2001 *PEAP: Building Partnerships* suggests that CSOs have a role to play in fighting corruption and should have been given the opportunity to feed into sector reviews (MoFPED 2001). Uganda also boasts a draft *National Policy on Public-Private Partnerships in Health* (MoH 2003).

²⁷⁶ A quick glance at the international literature on civil society reveals a multitude of terms that are used interchangeably to mean approximately (but not necessarily) the same thing, e.g. “voluntary and community organisations,” “civil society organisations,” “nonprofits,” “nongovernmental organisations,” and “charities.” As Riddell has acknowledged: “Civil society is a slippery concept for which there remains no definitional agreement.” (Riddell 2007: 302)

organisation's income, and fails to denote a philanthropic mission ("uncivil society" is all too real a phenomenon (Heinrich 2007)). Not surprisingly therefore, the idea of CSOs coming together – as the third sector - to mitigate against the failings of state and market is hugely flawed. As is the idea that inclusion is always the best avenue for civil society itself, especially while the scope of 'partnership' on offer remains deeply unequal. Yet these are the messages Uganda's development partners are uncritically promoting.

In encouraging civil society to partake in national processes and to compete for public sector funding, Uganda's donors are evoking the Hulme and Edwards (1997) proposition that CSOs risk losing their comparative advantages by getting "too close for comfort." Moreover, on the off chance that the 'good governance' agenda, or donors' faith in their role as 'watchdogs' is later called into question, Uganda's CSOs could well find themselves tossed aside and depleted of all the things that originally made them powerful in their own right.

As during the neoliberal era, the nation state continues to be problematised in development (Crewe and Harrison 1998). The difference is that in the era of 'good governance', civil society is universally championed. Such a binary framing is rationalised on the grounds of weak public sector capacity yet, as demonstrated using the Ugandan case study, this framing also serves to justify the attempted check on state power being attempted by donors in developing countries. This gentle subterfuge (although, I would suggest that it's quite apparent to all involved what is being attempted) is of course necessary in light of the principle of national sovereignty; furthermore, because donor organisations and the Global Health Initiatives can't be seen to meddle in national politics directly. As Ferguson (1990) and Escobar (1995) have established, the illusion of apolitical aid remains the most persistent framing in international development.

When employing their current tactic however, donors should stay alert to the unintended or "instrument-effects" (Ferguson 1990: 256 citing Foucault 1979; also Walt *et al.* 1999b) of their actions. With the Ugandan state so savvy to negotiating

change, and Ugandan civil society at present so unprepared for the challenge of coordination, donors may have already activated Ferguson's "anti-politics machine" in Uganda, which works by depoliticising "everything it touches...all the while performing, almost unnoticed, its own pre-eminently political operation of expanding state power" (Ferguson 1990: xv).

CHAPTER EIGHT:

THESIS CONCLUSION

The Rhetoric Versus The Reality Of Aid Coordination

This thesis has set out to show that aid coordination of the type extolled in the Paris Declaration on Aid Effectiveness (Paris High-Level Forum 2005), which uniformly weights the tenets of ownership, harmonisation, alignment, managing for results and mutual accountability, is not fully reflected in the reality of coordination activities being undertaken in Uganda's health sector. This is not to suggest that those values aren't important to the salient stakeholders, only that the rhetoric of coordination, which is after all venerated for its "intuitive force" (Buse and Walt 1997: 449; Walt *et al.* 1999a: 207) rather than its empirical grounding, was unlikely to translate into a workable set of aid management principles that could be applied in any context.

Therefore whilst Uganda's Development Partners may maintain that the foremost reason they group together is "to increase the effectiveness of development assistance in support of the national goals and systems of the Government of Uganda" (Local Development Partners Group Terms of Reference, 7), a closer look at their Terms of Reference alludes that it is a pragmatist's approach to partnership they are pursuing.²⁷⁷ Hence the admission that the Local Development Partners' Group (LDPG) is "first and foremost, a forum governed by the principles of consensus and it is respectful of differences regarding policies and modalities" (LDPG Terms of Reference, 10); and the caveat that "the principle of inclusivity must be observed. Financing modalities or agency specific procedures should not exclude any development partners from participating" (LDPG Terms of Reference, 6. iii.). Such assertions belie the suggestion that a Paris-style version of aid harmonisation is at work in Uganda's health sector, with inclusion and its

²⁷⁷ I.e. The umbrella grouping for all of Uganda's Development Partners sub-groups, including the Health Development Partners. See Appendix 3 for the LDPG Terms of Reference.

undisclosed advantage - strength in numbers - trumping the need to conform to a common set of standards or behaviours.

In their original critique of aid coordination, Walt *et al.* (1999a) noted that few of the coordination mechanisms they had witnessed in developing health sectors had excelled. To recap, this was because:

“few are led by recipient authorities, few embrace all donors active in the sector or a large proportion of aid, few command sufficient authority to ensure participant compliance, and as a result, few actually dramatically enhance the overall effectiveness of aid deployment or ensure that donor contributions support recipient goals. Fourth, it is admittedly difficult to judge the effectiveness or impact of aid coordination...” (Walt *et al.* 1999a: 213).

If one now applies these criteria to the coordination processes and mechanisms evoked by the Ugandan study, it is surprising how similar the findings are nearly a decade on from the original study. To sum up, the empirical chapters in this thesis have confirmed that the potential of coordination processes and mechanisms in Uganda’s health sector to attain their *stated* objective – i.e. to increase the effectiveness of aid – is mitigated across the board. The common barriers to meaningful coordination are the voluntary and non-punitive nature of partnership agreements and - the net consequence of such shaky foundations - differing levels of involvement and compliance by all stakeholders. How then to explain the tenacious commitment of all stakeholders to an ethos that remains unproven and resource-heavy at the country level in the face of superficially disappointing outcomes?

While it may be possible to identify several similarities with the Walt *et al.* (1999a) study, it only makes sense to suggest that coordination measures in Uganda’s health sector have *not excelled* if you accept aid effectiveness to be the primary goal of the exercise – something this study has refused to. Rather, this thesis has used a purposive case study of Uganda’s health sector to explore whether or not there might be additional fruits to be reaped from the labour of aid coordination. Subsequently, having reviewed the empirical findings, I would acquiesce that aid effectiveness is indeed the professed, long-term goal of coordination efforts in Uganda’s health

sector. Yet, it is the tangible short-term payoffs which explain partners' fidelity to that ideal .

Questioning What Coordination *Does*?

This thesis aligns itself with the school of development critique (e.g. Ferguson 1990; Escobar 1995; Crewe and Harrison 1998; Mosse 2005) that seeks to unpack development by asking the questions: how does development work? What does it *do*? Accordingly, this study has posed the question “what does aid coordination *do* in Uganda's health sector?” finding that actually it does quite a lot beyond its professed aim to improve aid effectiveness. At the macro level therefore, this study has posited that aid coordination permits the framing that aid to Uganda remains justifiable at current levels, in spite of repeated governance infringements (a point I shall expand upon in the next section). While at the micro level, the study has suggested that even a partial adherence to the aid coordination ethos throws up a host of rewards and/or fringe benefits which go some way to explaining partners' faithfulness to it.

Coordination's micro and short-term benefits were explored in the empirical chapters of the thesis and expressed in the form of Mosse-inspired propositions (Mosse 2004, 2005). To briefly recap:

Chapter Four 'Coordination to visibly pursue the most readily pick and mix element of the new aid agenda' used empirical data to establish the founding premise of this thesis: namely that aid coordination of the type extolled in the rhetoric of the Paris Principles is not reflected in the everyday reality of partnership activities in Uganda's health sector. This, it was argued, is the logical outcome of even (superficially) homogenous partners - in this instance the donor sub-group of the Health Development Partners (HDPs) - having to navigate their innate differences to pursue working relationships with their peers. The comparative difficulty of the HDPs then having to form working relationships with their counterparts in the host government was thereafter equated to the simile of square pegs and round holes. Rather than

dismiss the aid coordination ethos as unworkable however, Chapter Four makes the case that Uganda's stakeholders have pragmatically opted to interpret 'coordination' as just another slippery development term, which they can pursue on a partial basis without rejecting the overarching ethos. This was found to confer several discrete advantages on Uganda's Health Development Partners including 'strength in numbers', which the HDPs attained by masking their differences to present a united front in their dealings with government.

Chapter Five 'Coordination to Meet the Current Demands of the Contrary and Risk Averse Global Fund' challenged the premise that the current impetus for multiple stakeholders to feed into country proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is to ensure the production of participatory and needs-based proposals (which in theory should improve the utilisation and effectiveness of grants). Instead the chapter offsets the costly and time consuming imperative for partners to 'participate' in the proposal against the reactive policy evolution and reactive growth of the GFATM, which has seen the Fund make several u-turns in its policy toward Uganda and demonstrate an inability to manage risk. Coordination mechanisms and fora in Uganda were thus found to have availed the country of the requisite resources (e.g. Partnership Funds) to support GFATM proposal development and to oversee grant management (i.e. existing multi-stakeholder coordination fora have now subsumed the role of Country Coordinating Mechanism). Viewed together, the Fund's prioritisation of a quality-based over a needs-proposal and its insistence that all partners participate in GFATM processes at the country level can be construed as the Fund's attempt to introduce extra oversight over Uganda's grants following the 2005 embezzlement scandal. 'Coordination' therefore, has become the latest in a growing list of the GFATM's conditionalities or 'conditions precedent' for Uganda, i.e. another criterion the country must meet to access grants.

Chapter Six 'Coordination to Build Policy Consensus as an Act of Legitimation' alludes to the new competitiveness in the modern aid environment, arguing that there is a growing pressure for Uganda's Health Development Partners to *get policy right*

to justify their continued presence in Uganda's health sector. This premise is explored using two case studies: one of bilateral donor Danida and another of the UN's Specialised Agency for Health, the World Health Organisation. Both organisations are found to be capitalising on coordination fora and activities in the health sector to stay relevant (by staying relevant in policy). The idea of legitimacy with regards to policy-making is then explored using a very different case study subject: the US President's Emergency Plan for AIDS Relief (PEPFAR). Owning the threat posed by the HIV/AIDS pandemic and deriving its legitimacy from meeting its own targets, the PEPFAR program in Uganda is shown to have little interest in Uganda's domestic policy, and at best, a superficial interest in aid coordination. Found to be operating a very successful parallel delivery system for antiretrovirals in country, the PEPFAR programme also challenges the ideological foundations of the aid effectiveness agenda. Nevertheless, as PEPFAR transitions from its emergency phase to become a more embedded feature of the national HIV/AIDS response, there is at least the suggestion that the US aid programme will have to emerge from its relative isolation in Uganda to engage in some consensus building of its own.

Chapter Seven 'Coordination to Dilute State Control' sets out the role Uganda's health donors are playing in augmenting the space for civil society organisations (CSOs) in Uganda's health sector. Catalysing their transition from service providers to potential policy makers, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is found to have forced the hand of government to allow civil society representation in the country's most important multi-stakeholder sector forum for health, the Health Policy Advisory Committee; while the GFATM, together with several of Uganda's Health Development Partners and the US PEPFAR programme, are found to have vastly increased the funding envelop for civil society organisations operating in Uganda's HIV/AIDS field. While on the one hand the chapter argues that the impetus to carve out a greater space for CSOs is a natural consequence of the aid coordination ethos, it also posits that the donor prescribed changes could be construed as an attempt to dilute state power in Uganda. In this light, aid coordination has emerged as the acceptable means of situating watchdogs at the policy table, and of justifying the reallocation of large volumes of aid away from the

Ugandan government. However, whether or not the CSOs in question will benefit in the long-term from their elevated status in Uganda's health sector remains open to conjecture. Similarly, the best laid plans of the aid donors are called into question, for failing to take into account the Ugandan state's adept ability to ward off challenges to its dominance.

To conclude, it is the short-term properties that serve to explain the appeal of aid coordination in Uganda's health sector, rather than its long-term - and largely theorised - potential to render aid more effective.²⁷⁸

Prescribing Coordination, Turning Aid into a Stick

In Uganda's health sector, it is notable that the majority of the changes and/or innovations wrought by aid coordination appear largely donor driven, thus the notion of 'prescription' in this thesis (remember the advocacy for aid coordination originated on the side of the donors, with aid's recipients initially sceptical (Walt et al. 199a)). And because it is still the aid donors that set the development agenda, it is now *de rigueur* for external partners to demand a say in the "negotiation process proper" (Jeppsson 2002: 2059) in aid recipient countries; furthermore, that say has now been validated by the 2005 Paris Declaration on Aid Effectiveness, with its emphasis on principles like harmonisation, alignment and managing for results. The normalisation of Development Partners' expanded role is expressed in the vocabulary of 'partnership' and 'participation' at the country level. Consequently, one is now expected to accept that civil society is as important a player in the health sector as the government, and/or that external aid donors are well placed to feed into domestic policy. It is a state of affairs that is hard to reconcile with the principle of national sovereignty, yet it is one that I would argue has been instrumentally facilitated by the aid coordination drive.

²⁷⁸ Validating the premise of the aid effectiveness agenda will rely on the international community devising an empirical way to measure the impact of aid. At present there is no consensus over how this should be done (OECD/DAC Development Evaluation Network 2005), and health aid remains notoriously difficult to track (Centre for Global Development 2007).

Walt *et al.* commented on the unspoken power of aid coordination when they posited, “It would appear that interest in coordination is inextricably linked with influence, and that coordination tools, and particularly leadership therein, provide the potential to enhance leverage over policy direction or resource allocation” (Walt *et al.* 1999a: 215). Similarly, in Jeppsson’s reference to the “negotiation process proper” in Uganda’s health sector, the “process” is defined as the “stage where power relations interact,” while the power is imbued in the seemingly inconsequential details of “who directs the process, who participates in the process and who decides the boundaries of the sector and what it should contain” (Jeppsson 2002: 2059). Having conducted the Ugandan case study I strongly concur with these assessments. Having unearthed a host of bureaucratic devices used to determine who gets to participate in the processes and under what conditions in Uganda – moreover, having been excluded from certain coordination fora myself on the basis of a Memorandum of Understanding – it has become obvious to me that the devil is in the detail. Whether real or imagined, the pursuit of influence/power is inextricably tied up with the aid coordination drive at the country level. How else to explain the energy being expended on such vague undertakings as ‘dialogue strategies’ when the proffered reward (more effective aid) is unlikely to be achieved in the short-term or even prove quantifiable?

Yet I do need to qualify my stance, because while I align myself with the school of post-development critique that believes power is exercised through policy, practice and institutions (Ferguson 1990, Escobar 1995, Crewe and Harrison 1998, Cooke and Kothari 2001, Mosse 2005 etc), and hope that my study contributes positively to that body of work. I don’t hold with the idea that Uganda’s aid donors are neo-colonial bullies trying to dominate their host government, if for no other reason than I agree with Mosse (2005) Crewe and Harrison (1998) that donors just aren’t that powerful. What I hold with instead, is the notion of cautious and risk averse donors, who, having already been let down in Uganda, are attempting to find new ways of reassuring their national governments and tax payers that continuing to give aid to the country’s health sector is the correct undertaking. Aid coordination provides Development Partners with the practical means of doing this, because being able to

claim that as a donor representative you *personally* sat in on national budget discussions and/or participated in the Technical Working Group tasked with updating a strategic plan is extremely reassuring. Equally, if from your proximity to the “negotiation process proper” in Uganda (Jeppsson 2002: 2059), you can also convey to donor headquarters that the Ugandan government appears genuinely regretful of past mistakes and is now making great strides towards increasing transparency and forming closer working partnerships with external partners then all the better, because after all, a successful framing as Mosse (2005) has explained requires *all* the interpretative communities with something at stake to sustain it.²⁷⁹ Hence I must underline the critical role the Ugandan government has played and continues to play in doing just enough (and no more) to support the aid coordination drive in the health sector: engaging with donors, setting up public enquiries to investigate corruption, inviting civil society to join the Health Policy Advisory Committee. Yet all the while, keeping the reigns of decision making just out of reach.

The year 2005 represented a turning point in donor-government relations in Uganda, with the exposure of two financial scandals involving the GFATM and the Global Alliance for Vaccines and Immunisation (GAVI) turning out to be just the first in a series of events which have made the justification of aid to Uganda difficult to reconcile with donor concerns over governance (recall the slow move to multi-party politics, the removal of presidential term limits, and the threat of punitive anti-gay legislation). And yet the aid continues to flow, although significantly, it too has changed its dynamic. A strange corollary of the aid effectiveness drive has seen aid evolve (most specifically aid delivered as budget support) into a “stick” with which to beat bad performers. Equally, the mergence of disparate aid flows into single pots as donors increase the volume of ODA being channelled through pooled funding arrangements (e.g. basket funds and joint budget support) has made the multi-donor threat of mass aid reduction and/or withdrawal a possibility in Uganda. The ethos of aid coordination has facilitated both these developments.

²⁷⁹ Mosse has underscored the importance of *interpretative communities* in development, whereby: “the more interests that are tied up with their particular interpretations the more stable and dominant development policy models become.” (Mosse 2005: 8)

I would posit nonetheless, that the framing (Mosse 2005) underpinning the *coordinated* donor threat to reduce, withdraw or reprogramme aid away from direct budget support delivered by Uganda's Local Development Partners in February 2010 (Observer Media Ltd 2010) remains less stable than the alternate framing which permits donors to continue to provide ODA at current levels (and which I shall reiterate shortly). The empirical data in Chapter Four denoting the heterogeneity of Uganda's Health Development Partners and the repeated allusions to the non-conformist USAID/PEPFAR aid model belie the framing of *coordinated* or homogeneous donors. Furthermore, the recent donor ultimatum in Uganda is rendered unconvincing on several counts. Firstly, for ignoring the symbiotic relationship that exists between donors and recipients - each party needs the other, and in fact the donors probably need the recipients slightly more (Riddell (2007) has documented the proliferation of new aid donors over the last forty years). Therefore while the spectre of aid donors without recipients was raised in Chapter Five, the suggestion that donors would willingly put themselves out of a job is sadly unpersuasive; both the evidence that donors continue to give politically motivated aid and the chasm between the rhetoric and the bite of the good governance agenda argue against it.²⁸⁰

Secondly, one should not ignore the moral imperative attached to giving aid (Riddell 2007) and health aid in particular. Even the GFATM didn't cut all its inputs to Uganda when the mismanagement scandal broke – it continued to provide antiretrovirals during the grant suspension, and is in fact obliged to do so for two years in the event of future suspensions. Surely the same moral imperative applies to Uganda's other health donors, particularly if one concurs with the view that donors are to blame for the culture of aid dependency that now exists within the health sector (Erixon 2005).²⁸¹ Or with the assessment that foreign aid has actually proved the corrupting factor in Uganda's once unblemished reputation (Barkan 2005). With

²⁸⁰ Turn to Chapter One and the sub-section 'Introducing Aid Selectivity' to see how these points are grounded in the literature.

²⁸¹ Erixon's comment is not specific to Uganda. It simply states that aid in high volumes removes the incentive for recipient governments to balance their own books, a point with which Barkan (2005) agrees.

regards to the GAVI mismanagement, it was telling that even the Ugandan press felt compelled to point out that “The only people not yet indicted for gross negligence would be the donors writing cheques for monies used so irresponsibly” (Ssemogerere 2007). Viewed from this perspective, the checks and balances offered by the aid coordination drive might actually provide a means for donors to help rectify their past mistakes, by ensuring aid is used for what it’s intended, and by helping to reduce the culture of aid dependency in Uganda by encouraging aid to be channelled in directions that reap sustainable improvement. The only stumbling block to the check and balance – i.e. the ‘good governance’ - logic underpinning the broader aid effectiveness agenda is again national sovereignty. Once you reach a point where the checks and balances are being externally *prescribed* - where Development Partners conspire to speak with “one voice” and wield a “stick” when calling for reform, when the conditionalities of Global Health Initiatives impinge on national processes and change the composition of sector fora, and when donors conspire to bypass state systems altogether in favour of the unregulated and unaccountable third sector – then an infringement is surely imminent.

Finally, the “experimental nature” (Riddell 2007: 178) of official development assistance is an important backdrop to this discussion, because while Uganda’s Development Partners and the Global Health Initiatives may all have very clear ideas about what they would like the impact of their aid to be, as it stands the evidence base to support both their ideology and their strategies is absent:

“The discourse about the impact of official aid takes place on the mistaken assumption that there is sufficient evidence of sufficient quality ‘out there’ to prove that it works or that it doesn’t. As a result, far too much discourse about aid effectiveness is little more than a game of chasing shadows” (Riddell 2007: 255).

Thus while an understanding of aid’s trial and error approach would suggest that interested stakeholders need to exercise some patience - to wait and see if the ideology of aid effectiveness can be sustained by the practices. The inherent flaw in that logic, for the school of post-development critique at least, is that the site of aid’s experimentation is inevitably someone else’s country and that brings the discussion

back to sovereignty. Even when an aid-recipient country conspires to ‘participate’ in the experiment (as Uganda has with the GFATM for instance), the current power imbalance in the aid relationship renders the Paris ideals of ‘ownership’ and ‘mutual accountability’ hugely problematic. In short, is a country with defined needs and a notable resource gap really to turn down aid just because it comes with strings attached? Surely the more likely scenario – and the one seen playing out in Uganda with regards to the health sector – is that the government will conspire *alongside* its donors to keep the aid flowing. That this can be achieved using the rhetoric of ‘partnership’ and the mechanisms and processes of aid coordination is a finding of this study. In this way, the GoU should be depicted as a skilled aid “broker”, not a duped victim, and the country’s donors as development “translators” whose role is stabilise the dominant representation (Lewis and Mosse 2006).²⁸²

Indeed, out of all the factors considered, it is the experimental nature of aid that renders the donor threat to withdraw aid from Uganda unconvincing, because whilst Uganda – like much of the African continent since the colonial era - has long been a laboratory for the experimentation of donors, it has provided far more successes than its peers, and has, as a consequence, attracted a growing volume of external funding. An impressive record of economic growth, a marked reduction in the HIV/AIDS prevalence rate and policy innovations such as the Poverty Reduction Strategy Paper have rendered the country a ‘donor darling’ and an exemplar for what can be achieved with official development assistance. Uganda then has been crowned aid’s “success” story (Barkan 2005), a crown it retains despite marked concerns over governance and Museveni’s increasing resemblance to the archetypal ‘Big Man’.²⁸³ This, above all else, remains the dominant framing in which the majority of interests are tied up. Therefore while aid coordination may have made it possible for the country’s donors to turn aid into a “stick,” the threat in Uganda should be regarded as an empty one. Put simply, out of all the countries in development’s portfolio, the aid experiment cannot be allowed to fail in Uganda. Decades of investment preclude it.

²⁸² The terms development “brokers” and “translators” are introduced in Chapter Two of this thesis.

²⁸³ Chapter Two documents Uganda’s fall from grace in the first decade of the Twenty-First Century.

Even in the face of actual ‘failure’ – and in reality the means of measuring the impact of aid is not up to the task of denoting either success or failure at this time (see OECD/DAC Development Evaluation Network 2005; Centre for Global Development 2007) – what matters is that the parties involved won’t allow the aid experiment in Uganda to be allowed to be *seen* to fail. The ability to construct an interpretation that suits all parties is the essence of Mosse’s (2005) work on interpretative communities. The more likely scenario for an aid withdrawal in Uganda would be for donors to exit on a positive; for instance ‘Uganda has reached middle-income status and graduated from the need for future aid inputs’. Such a framing would allow all parties to separate unscathed, whilst cementing the notion of Uganda as aid’s great “success” story only further. Yet such an exit plan remains a far-fetched hypothesis for the time being.

The External Significance of Aid Coordination

In conclusion, I am unconvinced by the coordinated donor threat in Uganda and stand by my original proposition that while ostensibly aid coordination may appear to be important for its internal significance - as an organising principle to improve the effectiveness of aid - in fact, the value of coordination stems from its external significance. Aid coordination boasts tangible, short-term advantages. Moreover, in the medium-term it has become important for creating the façade of partner unity that now permits the continuance of aid flows to Uganda (in the face of serious governance concerns). In this view all partners are complicit in the framing that official development assistance to Uganda is at once necessary and effective, and its government cooperative and deserving.

While the tradition of aid coordination preceded the advent of the Paris Declaration on Aid Effectiveness, the widespread popularity of this international development commitment has only contributed to the stability of this framing in Uganda.²⁸⁴ The

²⁸⁴ The history of development would suggest that new aid commitments only have a short shelf life. A product of the “historical amnesia” (Easterly 2002) that afflicts the development industry, such

tenacity with which the international community maintains this framing attests that it isn't ready to let go of aid's "success" story just yet. Put simply, the repercussions of reframing Uganda as an aid "failure" would be too detrimental. Or at least for those involved in the highest echelons of the aid relationship, i.e. the "development brokers and translators" (Lewis and Mosse 2006).

Suggestions For Future Research

As acknowledged in Chapter Three, the thesis is by its nature a limited piece of research, which in this instance is demonstrated in my having taken Uganda's Health Policy Advisory Committee as my basic research sample. There remain other samples and lines of enquiry worth pursuing. Firstly, and in a sense this would have been the logical alternative for my own study if my access problems to the higher echelons had indeed proved intractable, there is a urgent need to explore the ramifications of the aid coordination ethos further down the hierarchy, at the level of the health care providers. To some extent I began this line of enquiry when I began to investigate the effects of aid coordination on those civil society organisations invited to join the HPAC in Chapter Seven. However, it is clear that the organisations I addressed in this study enjoyed an atypical status by virtue of their elevated status. A subsequent study is now needed to explore the ramifications of aid coordination at the district level in Uganda, among the service implementers not privy to the "negotiation process proper" (Jeppsson 2002: 2059), and to ask whether experiences here regarding the success or failure of international aid policy have any means of looping back into the national and international consciousness. In light of Mosse's (2005) writing on interpretative communities and dominant framings in development, one might assume probably not. Secondly, it would be pertinent to ask how the aid coordination drive is being played out in other government sectors in Uganda, if only to test that the hypothesis that donor interest in providing health aid is disproportionately high. It is feasible that other sectors may look very sparse in terms of active donors, thus undermining the need for a dedicated coordination apparatus. Thirdly, a future, complementary study would be useful to look at aid coordination across the East African region more broadly, to see how aid

amnesia allows for aid's constant reinvention, which as Mosse argues is necessary to keep aid and development "politically and morally viable" (Mosse 2005: 1).

coordination in the Ugandan example compares with the experiences of its neighbours.

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Long-Term Institutional Arrangement Documents

Doc 1:

September 2006. Proposed Long Term Institutional Arrangements for the Programmes of the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) In Uganda. Hard Copy

Doc 2:

Partnership Committee (of Uganda AIDS Commission). December 2006. Addendum to the Proposed Long Term Institution Arrangements for the GFATM Program on HIV/AIDS in Uganda: Structural and Institutional Framework of the Uganda HIV/AIDS Partnership. <http://www.aidsuganda.org/yeah/lterm.pdf> [Accessed 14/2/08]

Doc 3:

December 2006. Addendum to the Proposed Long Term Institutional Arrangements for the Programmes of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Uganda. Hard Copy

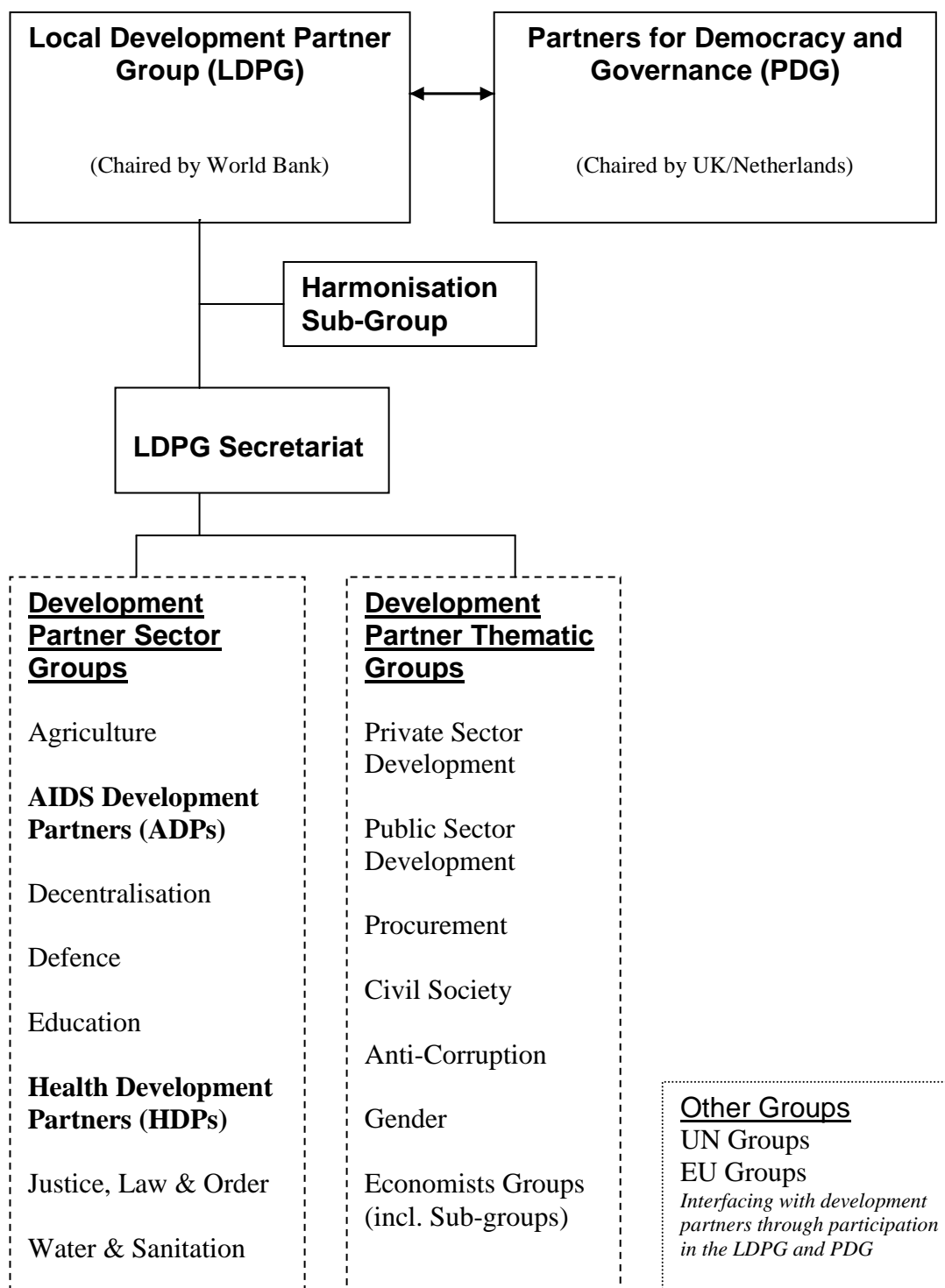
Doc 4:

Ministry of Health (of the Republic of Uganda). May 2007. Responses to Issues Raised by the Global Fund Secretariat on the Long Term Institutional Arrangement for Management of the Global Fund Grants in Uganda. Hard copy

Doc 5:

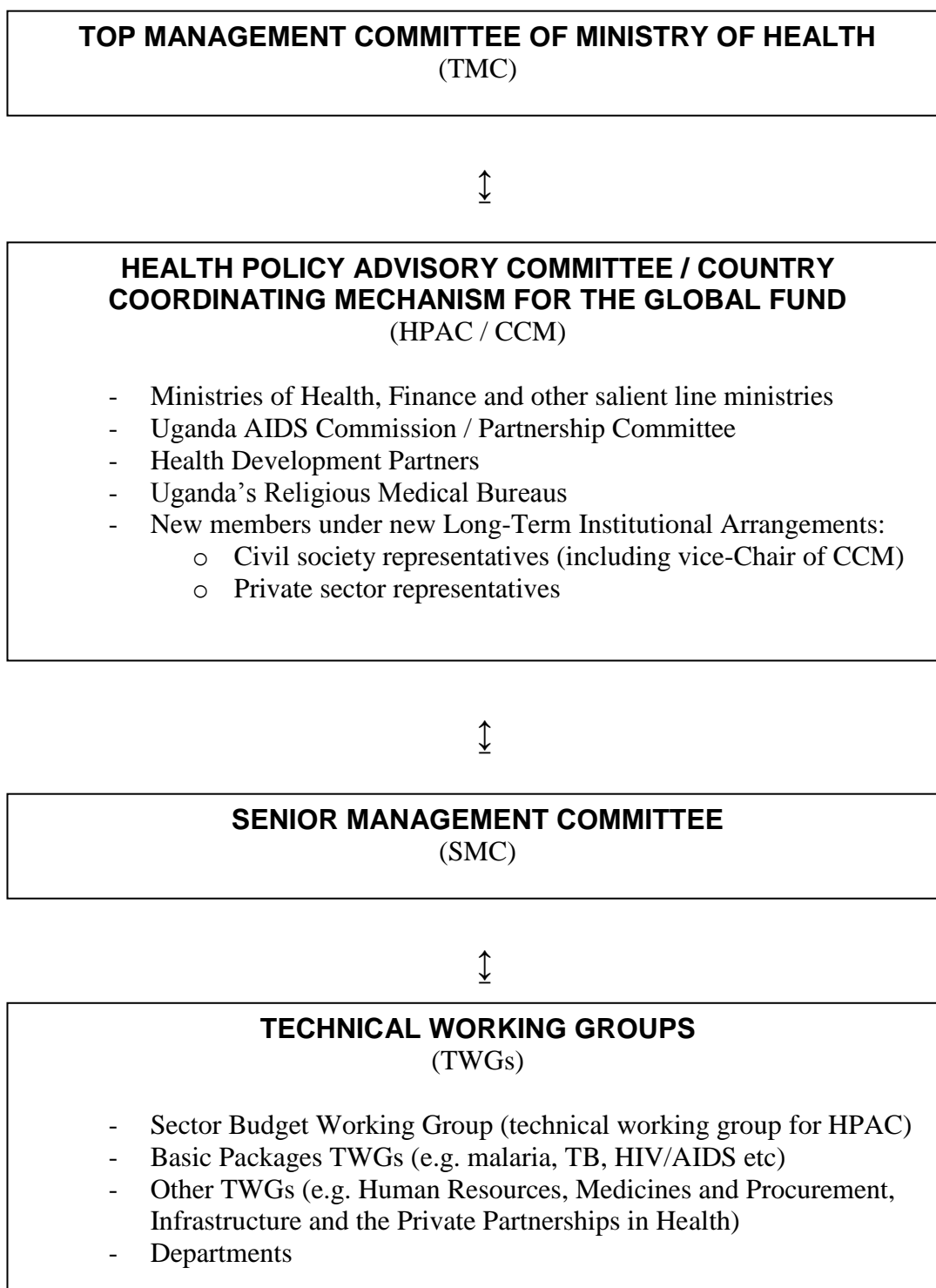
A Simplified Summary of the Approved Long Term Institutional Arrangements for Management of Global Fund and Other Donor Assistance. Hard Copy

APPENDIX 1: DEVELOPMENT PARTNER COORDINATION IN UGANDA



Source: Adapted from 'Health Sector Committee Structure Relationships' provided as hard copy (MoH Interview 7th April 2008).

APPENDIX 2: UGANDA'S HEALTH SECTOR ORGANISATIONAL STRUCTURE



Source: Adapted from Annex 3 to the LDPG Terms of Reference - 'Development Partner Coordination in Uganda' – provided as hard copy (BTC Interview 10th April 2008).

‘↕’ signals two-way flow of discussion

APPENDIX 3: LOCAL DEVELOPMENT PARTNER GROUP (LDPG) TERMS OF REFERENCE

Background

1. The Government of Uganda's Poverty Eradication Action Plan (PEAP) has been endorsed by development partners as the focus for all efforts to help reduce the incidence of poverty in the country. In 2003, Government and development partners signed the Partnership Principles as a framework to guide the delivery of development assistance to the PEAP. The Rome and Paris High Level Forums on Harmonization added an international context to local harmonization work with specific harmonization objectives spelt out in the Paris Declaration.
2. These developments have necessitated a more formal and structured approach from development partners than was provided so far by the LDG. These LDPG Terms of Reference are the result of that work. They may be amended by the LDPG at any time.

I. General Information

3. The name of the development partner's forum in Uganda will be the Local Development Partner Group (LDPG). It replaces the Local Donor Group (LDG).
4. Membership of the LDPG is open to any bilateral partner, multilateral bank and UN agency that provide development assistance to Uganda.²⁸⁵ The LDPG is a high level forum and LDPG representation will normally comprise of the Head of Missions and/or the Head of Agencies or Development Cooperation.
5. The objective of the LDPG is to increase the effectiveness of development assistance in support of national goals and systems of the Government of Uganda

II. Principles

6. The members of the LDPG recognize a set of principles that include the following, but may be reviewed, amended and augmented as necessary:
 - i) The PEAP is the principle instrument and overarching framework for Government and development partners. The rationale for the harmonization efforts in supporting the PEAP is to increase the effectiveness of the development assistance to Uganda. The PEAP offers an organized framework within which this takes place.
 - ii) The Partnership Principles are to be used by LDPG members to articulate the entry-point for delivering development assistance to the PEAP. It elaborates Government's vision for how partners engage in key processes such as the PEAP, PER/MTEF and poverty monitoring.
 - iii) The principle of inclusivity must be observed. Financing modalities or agency specific procedures should not exclude any development partners from

²⁸⁵ Membership currently comprises of ADB, Austria, Belgium, Denmark, European Commission, France, Germany, Ireland, Italy, Japan, Netherlands, Norway, Sweden, UK, UN, US, IMF and World Bank

participating in LDPG/Government work related to harmonization and implementation of the PEAP.

- iv) Each LDPG member will seek to ensure that any individual constraints to harmonization are acknowledged at an early stage so that solutions may be identified. This includes synchronizing headquarter missions in line with the calendar of key processes, promoting joint missions and, as far as possible, adhering to 'quiet times' agreed with government.
- v) The LDPG should be able to evaluate its overall performance (possibly using the indicators of progress of the Paris Declaration) in terms of facilitating Government delivery of outcomes. Collective and increasingly harmonized efforts of the LDPG should result in significantly improved effectiveness and quality of development assistance to Uganda while reducing transaction costs for both partners and Government.

III. Objectives

7. The central objective of the LDPG is to increase the effectiveness of development assistance in support of the national goals and systems of the Government of Uganda.
8. The LDPG will promote the wider application of the Rome and Paris Declarations by increasing stronger linkages with sector/thematic groups in order to:
 - i) harmonize dialogue at the policy, program and project levels;
 - ii) improve linkages to key processes (annual budget, PER/MTEF, PEAP implementation review) and the use of national systems for programming, financing and review;
 - iii) facilitate the use of joint reviews, joint analytic work and other harmonization initiatives;
 - iv) promote mainstreaming of all cross-sectional issues, including HIV/AIDS, which has been identified as a continued LDPG priority;
 - v) facilitate dissemination of best practice to other groups.
9. Sub-groups are encouraged to propose issues for discussion at LDPG meetings. This will allow nominated LDPG members to speak on behalf of the larger group in discussions with Government.

IV. Scope of Work

10. The LDPG is, first and foremost, a forum governed by the principles of consensus and it is respectful of differences regarding policies and modalities. This Section describes how LDPG objectives will be realised in practical terms through the conduct of LDPG meetings.
11. **Sector Issues:** Prior to the monthly LDPG meetings, the Secretariat will coordinate with donor sector groups to highlight sector issues that need to be discussed with the Economist Group for any feedback prior to the LDPG meeting. Sector issues may be included on the agenda and a representative of a relevant sector would be invited to provide a short briefing to the LDPG.

12. **Special Issues:** Each meeting may consider a topic of special interest. This may be informed by forthcoming national meetings/events (budget, PER, PEAP etc) or by nomination by a LDPG member. Special issues should attempt to meet the LDPG objectives.
13. **Standing Briefs:** Standing briefs (economy, PEAP, harmonization etc) will be shared, as needed, electronically before each monthly meeting through Secretariat. Questions regarding these briefs may be raised at the meeting.
14. LDPG members may also consider joining the Uganda Joint Assistance Strategy (UJAS) in support of the Government's PEAP (including *inter alia* embarking on a joint annual review and sharing joint analytical work). The update of this document would be synchronized with Government's PEAP revision process to allow full alignment and consistency with the new PEAP.
15. The Scope of Work will be reviewed whenever felt to be appropriate to ensure that LDPG work is both meaningful and focused.
16. At the LDPG meetings, conclusions will be formulated and agreements will be made on the basis of voluntary consensus. The LDPG will agree amongst its members how work will be taken forward, particularly with regard to follow-up discussions with Government and who will be responsible for its oversight.

V. Organization

17. The LDPG will have one Chair and one Deputy Chair. The Chair will be the World Bank Country Manager (or designate) and the Deputy will be selected among bilateral development partners from the LDPG on a one year rotating basis. The World Bank Country Office will provide the permanent Secretariat and maintain the records of the LDPG
18. The Chair will represent the views of the LDPG members in further consultations with Government or other institutions. Where it is deemed necessary to have a larger group meeting with Government partners, the meeting will agree on the most appropriate members to best represent the issues involved. Equally, the LDPG may nominate any other members to speak on their behalf if this is felt to be more appropriate.
19. The LDPG will meet at 10am on the second Tuesday of each month. The Secretariat will issue a notice in advance confirming the meeting. The LDPG may agree to alter the date of a meeting or decide not to hold a meeting in a particular month. At the time of issuing notice of the meeting, the Secretariat will circulate a detailed agenda including issues raised by sector groups (see para 11), depending on the situation. Individual members may propose issues to be included on the agenda. These proposals may be made in due time to the Secretariat. The Secretariat will draft and circulate minutes of the previous meeting, together with the agenda of the forthcoming meeting to members in due time. Communication shall normally be by email.
20. The Secretariat, in conjunction with, and under the direction of the Chair, will be responsible for following up agreements made at the LDPG meeting, as directed by LDPG members.

Source: the 'Local Development Partners Group Terms of Reference' were supplied as hard copy (BTC Interview 10th April 2008).

APPENDIX 4: HEALTH DEVELOPMENT PARTNERS (HDPs) GROUP TERMS OF REFERENCE

May 31 2006

It has been agreed that a formal structure be established to coordinate the Development Partners working in the health sector in Uganda. To this end the Health Development Partners' Group has been formed.

1. Membership

The group is open to representatives from all organisations/agencies listed in the Memorandum of Understanding between the Ministry of Health (on behalf of the Government of Uganda) and the Development Partners dated 23rd August 2000. In addition representatives from other stakeholder groups will be invited from time to time to participate in meetings.

2. Purpose of this Group

2.1 The group is not intended to duplicate function of HPAC or any existing group.

2.2 The purpose of the group is to:

- a) Provide a more formal forum for coordination between the Development Partners working in health;
- b) Reduce transaction costs for both agencies and Government in implementing the Health Sector Strategic Plan, and
- c) Strengthen the partnership between GoU and Development Partners to ensure more effective implementation of HSSP through the health SWAp process.

2.3 Specifically it will:

- i. Provide a forum for discussion on issues in the health sector;
- ii. Enable partners to coordinate and collate joint responses to issues in the health sector and to key studies and other documents;
- iii. Provide a means by which the partners can communicate amongst themselves and with the Ministry of Health more effectively;
- iv. Provide a forum to discuss issues raised or to be raised at HPAC and make recommendations for issues to be included on the HPAC agenda in the future;
- v. Enable HDPs to contribute more effectively to the Joint [Review]

Mission in the sector by:

- Supporting HPAC to ensure that the review of progress against the undertaking from the previous joint [review] mission and a general programme review happens well in advance of the joint [review] mission.
- Coordinating input from the HDPs to the agenda of the joint [review] mission at least one month in advance of the scheduled start of the mission.
- Contribution to the organisation of the programme as required, including district visits.
- Coordinating HDP involvement in the Aide Memoire writing group.
- Supporting to ensure that appropriate follow up action takes place after the joint [review] mission, including finalisation and circulation of the undertakings

- vi. Provide a forum for coordination of input from the HDPs into CG Process as it relates to the health sector.
- vii. Enable the HDPs to liaise with other relevant coordination mechanisms and NGOs to ensure a wider understanding of the issues in the health sector and wider participation in policy and other debates.

3. Consensus/Joint Ownership

- 3.1 Throughout, the emphasis of HDP will be on joint ownership of the process and building consensus.
- 3.2 However, if it is not possible to reach consensus on any issue, any minority views will also be represented to the Ministry of Health.
- 3.3 It is recognised that WHO has a global mandate to take the lead in health technical issues. Any technical health opinion expressed by WHO should not be considered a minority view.
- 3.4 The existence of the Group does not preclude individual contacts between agencies and the Ministry of health, though it is hoped that it may reduce the need for many such meetings.

4. Meetings

- 4.1 The group will normally meet once a month.
- 4.2 If necessary additional meetings may be called in between the regular monthly meetings. This is especially likely to happen during the preparation for Joint [Review] Missions.
- 4.3 When necessary, ad hoc sub-groups may be set up to carry out specific tasks.

5. Coordination of HDP

One agency will take on the coordinator [Chair] of HDP for a period of one year (July-June). Separate terms of reference are provided for the coordinator.

6. Review

The functioning of the HDP and the coordination process will be reviewed after every 6 months and any changes to these terms of reference deemed necessary will be made following each review and by consensus from HDP members.

Source: the 'Terms of Reference for the Health Development Partners Group' were provided as hard copy (BTC Interview 10th April 2008).

APPENDIX 5: HEALTH POLICY ADVISORY COMMITTEE (HPAC) TERMS OF REFERENCE

Purpose and Establishment

1. The Health Policy Advisory Committee (HPAC) was established as a forum for the Government, Development Partners and other stakeholders to discuss health policy and to advise on the implementation of the Health Sector Strategic Plan.
2. HPAC is a donor/stakeholder coordination mechanism. It uses and works through the established Ministry of Health structures and systems.

HPAC Membership

Permanent members²⁸⁶

3. HPAC will consist of:
 - Ministry of Health
 - Development Partners who are signatories to the Memorandum of Understanding
 - Ministry of Local Government
 - Ministry of Finance, Planning and Economic Development
 - Water Development Department
 - Ministry of Education and Sports
 - Ministry of Public Service
 - Religious Medical Bureaus, and
 - Uganda Community Based Health Care Association

Co-opted members

4. From time to time, HPAC may co-opt members to address specific issues that may arise. Members may be co-opted from external organizations that are not necessarily operating in the health sector, other Government Ministries and departments, district officials and NGOs. The time period and tasks for co-opting more members will be specified.
5. In line with the Sector-Wide Approach (SWAp) principle of the Government taking the leadership of the policy process, HPAC will be chaired by the Director General of Health Services, who is the technical head of the health sector.
6. In the absence of the Director General one of the two Directors at the MoH headquarters will act in his place.
7. The HPAC Secretariat will be in the Health Planning Department. One Health Planner will be designated as Secretary to HPAC.

HPAC Meetings

8. HPAC will meet at least once quarterly.

²⁸⁶ Please note that this version of the Terms of Reference precedes 2007, when permanent membership of the HPAC was extended to include civil society and private sector representation in line with the new Long-Term Institutional Arrangements for the Global Fund for AIDS, TB and Malaria.

Other functions of HPAC

9. HPAC will also provide a forum for information and experience sharing.
10. HPAC will provide a forum for the resolution of disagreements or conflicts among health sector stakeholders.
11. HPAC will identify tasks that need to be undertaken through special assignments. The assignments will largely be carried out by the Ministry or other Government departments. HPAC will propose terms of reference for each such assignment. Working Groups may be established to carry out specified assignments.
12. HPAC will approve the work plan, budget and expenditures for the Partnership Fund and receive quarterly statements on the use of the Fund.

Duration of HPAC

13. HPAC will remain in operation during the entire period of the health Sector Strategic Plan II, or as long as will be jointly agreed by the Government and its Development Partners.
14. The Terms of Reference of HPAC will be reviewed from time to time to reflect appropriate response to changing health needs.

Funding

15. All HPAC activities including special assignments will be funded from the Partnership Fund.

Source: The 'Terms of Reference for the Health Policy Advisory Committee' are included as Annex 6 to the 'Memorandum of Understanding Between the Government of Uganda and the Development Partners' - and were provided as hard copy (BTC Interview 10th April 2008).

APPENDIX 6: 2005 MEMORANDUM OF UNDERSTANDING BETWEEN UGANDA'S HEALTH DEVELOPMENT PARTNERS AND THE GOVERNMENT OF UGANDA

MEMORANDUM OF UNDERSTANDING between the Government of Uganda and the following Development Partners:

African Development Bank
Austrian Agency for International Development
The Kingdom of Belgium
Danish International Development Assistance
Commission of the European Union
Development Cooperation Ireland
Department for International Development of the United Kingdom
French Cooperation
German Development Cooperation
German Development Services
International Development Association – World Bank
Italian Cooperation
Japan International Cooperation Agency
Netherlands Cooperation
Norwegian Agency for International Development
The Kingdom of Spain
Swedish International Development Cooperation Agency
United Nations Population Fund
United Nations Development Programme
United Nations Children's Fund
Joint United Nations Programme On HIV/AIDs
United Nations High Commission For Refugees
United States Agency For International Development
World Food Programme
World Health Organization

THIS MEMORANDUM OF UNDERSTANDING made this day of 2005 between the Government of the Republic of Uganda, represented by its Ministry of Health P.O. Box 7272, Kampala, Uganda (here in after referred to as the Government) of the one part and Development Partners of the other part.

WHEREAS the Government is desirous of continuing to implement the National Health Policy and the second Health Sector Strategic Plan (herein referred to as HSSP II) for the duration of five years, from July 2005 to June 2010, through a sector-wide approach.

AND WHEREAS the Development Partners are in agreement to implement a sector-wide approach, which will address the health sector as a whole in planning, monitoring and in allocation of resources.

AND WHEREAS the Government and Development Partners (herein after referred to as all parties) agree to support common programs of work in which planning, review, monitoring and policy development are undertaken as joint effort through consultation.

NOW THEREFORE all parties agree as follows:

Section 1: Interpretation

This Memorandum of Understanding is not a legal document but reflects the commitment of all parties, who recognize it as guidelines in which the health sector operationalizes the partnership in the implementation of the Health Sector Strategic Plan II.

Section 2: Objectives of the Sector-Wide Cooperation

- 2.1 The overall objective of cooperation under this Memorandum of Understanding is to implement the National Health Policy and Health Sector Strategic Plan II through a sector-wide approach, which addresses the health sector as a whole in planning and management, and in resource mobilization and allocation.
- 2.2 The Uganda Health SWAp is here defined as: “a sustained partnership led by national authorities, with the **goal of achieving improvements in people’s health** in the context of a coherent sector, defined by an **appropriate institutional structure** and **national financing programme** through a **collaborative programme of work**, with established **structures and processes for negotiating strategic and management issues**, and reviewing sectoral performance against **jointly agreed milestones and targets**.”

Section 3: Obligations of the Government

The Government undertakes, where practically possible and in line with general Government policy, to:

- 3.1 Provide overall leadership in planning, administration, implementation and monitoring of Health Sector Strategic Plan II.
- 3.2 Make financial contributions as detailed in the annual approved work-plan and budget and ensure timely release of such funds.
- 3.2 ensure that all district health plans (strategic and operational) are consistent with the Health Sector Strategic Plan II.
- 3.3 Endeavour to ensure that all resources for the Health Sector Strategic Plan II are reflected in the resource envelope and the Medium and Long Term Expenditure Frameworks, following the guidance provided by Ministry of Finance.
- 3.5 Ensure that the proportion of the overall Government budgetary allocation to the health sector increases annually in real terms over the five-year period of the Health Sector Strategic Plan II. This is clarified in the “Official Statement on the Government’s Commitment to Financing the Health Sector.”

Financial resource requirements and gaps detailed in the Health Financing Strategy, HSSP II shall be available to the Ministry of Finance and partners.
- 3.6 Ensure that there is an effective reporting system to provide financial and health management information data on time.
- 3.7 Consult all development partners prior to any changes in health policy or the Health Sector Strategic Plan II. This consultation shall be carried out in accordance with the agreed processes of collaboration.

- 3.8 Negotiation between the Ministry and Health and partners is officially made known to all stakeholders.
- 3.9 Ensure that all partnership structures are operational.

Section 4. Obligations of Development Partners

The development partners shall:

- 4.1 Synchronize their own planning, review and monitoring processes as far as possible with those established to monitor the implementation of the Health Sector Strategic Plan II.
- 4.2 Synchronize their support and activities with the Government budget cycle of July to June.
- 4.3 Adopt the use of Government systems except where specifically negotiated and agreed to and indicated in writing by the partner or bilateral.
- 4.4 Provide comprehensive information regarding resources provided to third parties to support the health sector in Uganda. Also endeavour to ensure that these parties actively coordinate with Ministry of Health and that these resources support the HSSP II.
- 4.5 Negotiate with Ministry of Health all new programmes or initiatives in matters of health and health services to be implemented in the districts before going to the Local Government and must be included in the district annual work plan.
- 4.6 Ensure that the support provided should as much as possible avoid distorting the existing government systems and strategies.
- 4.7 Use the existing Health Management Information System (HMIS).

Section 5. Obligations of Both Government and Development Partners

All parties shall:

- 5.1 Fund only activities that are reflected in the framework of the Health Sector Strategic Plan II.
- 5.2 Aim to meet agreed disbursement commitments in a timely manner and as detailed in the agreed work plan and budget.
- 5.3 Ensure that financial information in all grants and credits, including details of procurement and technical assistance, are provided in a timely manner to the Ministry of Finance and reflected in the plans and budgets of Government.
- 5.4 Bring to the attention of all parties any cases of non-compliance with the Government rules and regulations.
- 5.5 Ensure the mainstreaming of gender, governance, HIV/AIDS and environmental issues in their policies, planning, service delivery and evaluation.
- 5.6 As provided in the Constitution of Uganda, ensure that other marginalized groups of society such as the poor, the displaced and the disabled are specifically addressed.
- 5.7 Aim at increasing annually the total funding by all parties to the health sector over the five-year period of the Health Sector Strategic Plan II.

- 5.8 Collectively rationalize the existing partnership structures to ensure efficiency and better alignment with structures of HSSP II.
- 5.9 Use the principles of the MoU as the basis for any negotiation for support to the health sector. The support negotiated should have long-term commitment and clear strategies for financial sustainability and exit strategies.

Sector 6: Co-operation Among Partners

6.1 Planning

- 6.1.1 The Government shall develop an organizational framework and structures for the partnership which will be reviewed by all parties during the joint review mission.
- 6.1.2 The Health Policy Advisory Committee (HPAC), on which the Government and Development Partners are represented, shall advise the Government on the implementation of Health Sector Strategic Plan II and will meet at least quarterly.
- 6.1.3 Partners shall make greater use of the Inter-agency Coordination Committees (ICCs), Country Coordinating Mechanisms (CCMs) and the health sector Working Groups (SWG) to undertake the bulk of the detailed work and feed up to the HPAC for strategic decision and oversight. These structures are subsidiary and must regularly report to HPAC and the SWG.

6.2 Monitoring and Review

- 6.2.1 The Joint Review Mission (JRM) shall be held once a year. The mission will review the performance of the health sector during the previous financial year and agree on sector priorities and resource allocation for the next Financial Year. The JRM shall also monitor the implementation of the MoU.
- 6.2.2 The Sector Working Group shall discuss and endorse the Budget Framework Paper for the health sector including Ministry of Health Headquarters, determine and assess the project proposals. The SWG shall also review and endorse revision of the budget.
- 6.2.3 The Health Policy Advisory Committee shall receive regularly the following monitoring reports:
- Quarterly Area Teams monitoring reports
 - Quarterly Ministry of Health performance review report
 - Quarterly progress report on implementation of JRM undertakings.
- 6.2.4 The Government shall organize a Joint Midterm Review (JRM) and an End Evaluation by all parties of the implementation of Health Sector Strategic Plan II, which will take place before the end of the third year and the last quarter of implementation respectively. All parties shall agree on the timing, terms of reference and composition of the review mission and end evaluation, and on preparatory studies to be undertaken in advance of the missions.
- 6.2.5 The Monitoring and Evaluation Matrix of the Health Sector Strategic Plan II shall specify indicators to monitor the performance of the sector and shall provide a basis for the review and evaluation.
- 6.2.6 The Government shall continue to hold the National Health Assembly in which districts, urban authorities, central ministries, NGOs and other stakeholders, including development partners will be expected to participate. The National Health Assembly will be held at least once every two years. The Government will define the terms of reference of the assembly, which shall be advisory.

6.3 *Sector Reporting*

The Government shall, based on annual output targets, produce an annual report on the performance of the sector within three months of the end of every financial year. The annual report shall contain league tables of performance against agreed indicators for districts, hospitals and Ministry of Health departments and divisions.

6.4 *Financial Systems*

- 6.4.1 Development Partners shall make all endeavours towards channelling resources using existing Government systems of budgeting, disbursement, accounting and audit, and where necessary, take steps to strengthen these systems. The Ministry of Health shall be audited by Auditor General once annually and this will be supplemented by periodic external independent audit as agreed by all parties.
- 6.4.2 Partners shall use government's preferred funding option i.e. direct budget support, taking into account their policies and legal obligations. Other funding mechanisms used include:
- Supply of specific goods and services
 - Stand alone donor designed and managed projects
 - Traditional project aid integrated into HSSP II
 - Earmarked support for specific programme area e.g. GAVI, RBM, TB.
- 6.4.3 Financial flows audit (tracking study), covering 3 – 4 previous financial years shall be conducted and the report presented at the Joint Review Mission. Audits of agreed financial sub-systems such as payroll and value-for-money audits shall also be conducted as and when necessary and also presented to the Joint Review Mission.
- 6.4.4 Development partners shall recognize the importance of timely disbursement of funds and shall work towards ensuring that budget releases are made according to a schedule agreed with the Government

6.5 *Procurement*

- 6.5.1 Development partners shall work towards the use of Government procurement procedures taking into account the legal obligations of the development partners. Cost effectiveness and value for money will be guiding principles in procurement.
- 6.5.2 Routine, pooled procurement through the national procurement agency (agencies) and common logistics management is the preferred option. In the case of specialised procurement or requirements outside the scope or capacity of the national procurement agency (agencies), other procurement modalities may be used. These include:
- International joint procurement services that respond to national procurement plans (e.g. for new vaccines or other commodities characterised by limited manufacturing capacity or unfavourable market dynamics).
 - Procurement and management through projects or other specialised arrangements (e.g. for ARVs through GFATM) for limited period with appropriate steps to strengthen national procurement capacity and to integrate procured commodities into existing national logistics management systems.
- 6.5.3 The provisions in paragraph 6.5.1 shall apply to the procurement of services, goods, works, medicines and other supplies. All parties will work towards the continued improvement in information flow and transparency in this area.
- 6.5.4 An Annual procurement plan integrating all the planned procurement in the health sector shall be prepared and appraised by stakeholders. The plan shall integrate all procurement by

both government and development partners. Quarterly progress report on the implementation of the procurement plan shall be availed to stakeholders.

6.6 Technical Assistance

- 6.6.1 Short term Technical Assistance shall be identified and determined on a demand driven basis according to the needs and priorities of the Government in consultation with Development Partners. Use of Ugandan or regional consultants will be encouraged where expertise is available. Terms of reference will be developed by the Government and agreed with Development Partners. Candidates for technical assistance shall be reviewed and approved by the Government and development partners. The forum to discuss Technical Assistance will be the Health Policy Advisory Committee.
- 6.6.2 Long Term Technical Assistance to the Ministry of Health will be determined on a demand driven basis according to the identified gaps in the sector. Terms of reference will be developed by the MOH and posts will be advertised regionally and internationally. Caution will be taken to ensure that any recruited TA does not work as an extra pair of hands but offers high-level technical advice and builds the capacity of relevant people and systems in the department. The TA will be supervised by the Commissioner (first level supervisor) of the relevant department. Termination of contract or request for renewal will be accompanied by an appraisal report, which should be discussed between the TA and first level supervisor and signed by the Director General. In the event that a national assumes the functions of a TA, remuneration should be on the same terms as for international staff.

6.7 Understanding of Sector-Wide Approaches (SWAp)

Periodic refresher seminars on SWAp principles shall be organized for health sector stakeholders, preferably every year, in order to:

- Update stakeholders on SWAp principles, and
- Help minimise misunderstanding.

Section 7: Collaboration with the Private Sector

- 7.1 All parties recognize the important role the private sector is playing in health service delivery and resource mobilization. The parties further recognize that there are four categories of private health care providers in Uganda, each of which plays a unique role in the health sector. These are:
- a) Religious Non-Governmental Organizations (Facility Based)
 - b) Other Non-Governmental Organizations, including community based organizations (Non Facility Based)
 - c) Private enterprises such as private clinics, pharmacies and hospitals
 - d) Traditional healers, including traditional midwives.
- 7.2 All Non-Governmental Organizations (NGOs) delivering services at the district level shall be required to negotiate with the Ministry of Health before going to the districts. They will be required to plan with and report to the designated District and Health Sub Districts officials in their areas of operation
- 7.3 All the above categories of the private sector are partners in the implementation of the Health Sector Strategic Plan. Collaboration between the parties to this Memorandum of Understanding with the private sector shall be through mechanisms of collaboration already established or that will be established between the Government and the private sector partners, as well as between Development Partners and private sector partners.

Section 8: Prevention and Settlement of Disagreements and Conflicts

- 8.1 The Parties shall work in a spirit of openness, transparency and consultation. Effective information flows and dialogue are crucial in building and sustaining confidence and trust.
- 8.2 All parties shall adhere to the Code of Conduct.
- 8.3 In the event of disagreement or conflict, dialogue will be the first recourse for resolving the problem. The Health Policy Advisory Committee and the Joint Missions offer opportunity to identify and address potential problems. Unilateral actions shall be avoided.
- 8.4 In the event of continuing disagreement a high level meeting shall be arranged between Government and the development partner (s) with a two-week period of notice.

Section 9: Amendment/Termination of Memorandum of Understanding

- 9.1 Any amendments to the terms, operational modalities and change of status or name of any of the parties to this Memorandum of Understanding may only be made through written agreement between the Government and development partners who are signatories to the Memorandum of Understanding.
- 9.2 Termination of this agreement may be effected by any signatory on giving 90 days notice (which will include the reasons for the termination) to all partners.

Section 10: Inclusion Of New Development Partners

Any new partners wishing to cooperate with the Government under the provisions of this Memorandum of Understanding will be free to do so upon signing this Memorandum of Understanding. The new partners must present their programmes to the partners.

The Memorandum of Understanding will be posted on the MoH website.

Section 11: Commencement Date

This Memorandum of Understanding shall be deemed to have come into effect upon signing by respective representatives of the Government and the development partners, and shall be effective for the five years of the Health Sector Strategic Plan II.

IN WITNESS WHEREOF the undersigned being duly authorized representatives of the parties hereto, have signed this Memorandum of Understanding on the day and year first above written.

**Permanent Secretary, Ministry of Health
FOR THE GOVERNMENT OF THE
REPUBLIC OF UGANDA**

AND

FOR THE DEVELOPMENT PARTNERS

(Authorised Representative)
AFRICAN DEVELOPMENT BANK

(Authorised Representative)
AUSTRIAN AGENCY FOR INTERNATIONAL DEVELOPMENT

(Etc...)

Source: the 'Memorandum of Understanding Between the Government of Uganda and the Development Partners' was supplied as hard copy (BTC Interview 10th April 2008).